



CONTRACT AMENDMENT COVER SHEET

Agency Tracking # 31866-00026	Edison ID 29635	Contract #	Amendment # 40		
Contractor Legal Entity Name VSHP (TennCare Select)			Edison Vendor ID 0000071694		
Amendment Purpose & Effect(s) Updates Scope, Extends Term, Increases Maximum Liability TennCare Managed Care Organization / Medically Necessary Health Care Services					
Amendment Changes Contract End Date: <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		End Date: December 31, 2017			
TOTAL Contract Amount INCREASE or DECREASE per this Amendment (zero if N/A):			\$ 528,046,700.00		
Funding					
FY	State	Federal	Inter-departmental	Other	TOTAL Contract Amount
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$ 18,599,868.48
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$ 33,079,942.80
2004	\$ 25,125,990.72	\$ 38,364,165.90			\$ 63,490,156.62
2005	\$ 58,007,447.00	\$ 58,007,447.00			\$ 116,014,894.00
2006	\$ 87,748,111.00	\$ 87,748,111.00			\$ 175,496,222.00
2007	\$ 87,748,111.00	\$ 87,748,111.00			\$ 175,496,222.00
2008	\$ 72,610,000.00	\$ 127,390,000.00			\$ 200,000,000.00
2009	\$ 72,610,000.00	\$ 127,390,000.00			\$ 200,000,000.00
2010	\$ 100,882,479.00	\$ 304,024,121.00			\$ 404,906,600.00
2011	\$ 131,086,619.00	\$ 312,820,981.00			\$ 443,906,600.00
2012	\$ 149,893,942.00	\$ 294,012,658.00			\$ 443,906,600.00
2013	\$ 150,102,578.00	\$ 293,804,022.00			\$ 443,906,600.00
2014	\$ 153,147,777.00	\$ 290,758,823.00			\$ 443,906,600.00
2015	\$ 155,078,771.00	\$ 288,827,829.00			\$ 443,906,600.00
2016	\$ 155,211,942.69	\$ 288,694,657.31			\$ 443,906,600.00
2017	\$ 175,085,000.00	\$ 324,915,000.00			\$ 500,000,000.00
2018	\$ 87,542,500.00	\$ 162,457,500.00			\$ 250,000,000.00
TOTAL:	\$ 1,684,421,329.04	\$ 3,116,102,176.86			\$ 4,800,523,505.90
American Recovery and Reinvestment Act (ARRA) Funding: <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
Budget Officer Confirmation: There is a balance in the appropriation from which obligations hereunder are required to be paid that is not already encumbered to pay other obligations.				<i>CPO USE</i>	
Speed Chart (optional)		Account Code (optional)			



**AMENDMENT NUMBER 40
AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.**

CONTRACT NUMBER: FA-02-14632-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as specified below.

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. **The Service Chart in Section 2.6.1.4 shall be amended by deleting "Mental Health Case Management" and replacing it with "Behavioral Health Intensive Community Based Treatment" as follows:**

SERVICE	BENEFIT LIMIT
Behavioral Health Intensive Community Based Treatment	As medically necessary.

2. **Section 2.7.2.1.3 shall be amended by deleting and replacing Section 2.7.2.1.3.2, adding a new Section 2.7.2.1.3.3 as follows, and renumbering the remaining Section accordingly, including any references thereto.**

2.7.2.1.3.2 Intensive Community Based Treatment Service agencies

2.7.2.1.3.3 Tennessee Health Link Providers

3. **Section 2.7.2.6 through 2.7.2.6.5.3 shall be deleted and replaced as follows:**

2.7.2.6 Behavioral Health Intensive Community Based Treatment Services

2.7.2.6.1 The CONTRACTOR shall provide Behavioral Health Intensive Community Based Treatment Services only through providers licensed by the State to provide mental health outpatient services.

2.7.2.6.2 The CONTRACTOR shall provide Behavioral Health Intensive Community Based Treatment services according to the standards set by TENNCARE and outlined in Attachment I.



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- 2.7.2.6.3 Tennessee Health Link
- 2.7.2.6.3.1 The CONTRACTOR shall provide Tennessee Health Link services according standards set by TENNCARE and outlined in Attachment I.
- 2.7.2.6.4 The CONTRACTOR shall require Tennessee Health Link Care Coordinators to involve the member, the member's family or parent(s), or legally appointed representative, PCP, care coordinator for CHOICES members, and other agency representatives, if appropriate and authorized by the member as required, in mental health case management activities.
- 2.7.2.6.5 The CONTRACTOR shall ensure the continuing provision of Tennessee Health Link services to members under the conditions and time frames indicated below:
 - 2.7.2.6.5.1 Members receiving Tennessee Health Link services at the start date of Tennessee Health Link program operations shall be maintained in Tennessee Health Link until such time as the member no longer qualifies on the basis of medical necessity or refuses treatment;
 - 2.7.2.6.5.2 Members discharged from psychiatric inpatient hospitals and psychiatric residential treatment facilities shall be provided with appropriate follow-up behavioral health services. If eligible, members will be referred to Tennessee Health link for services; and
 - 2.7.2.6.5.3 The CONTRACTOR shall review the cases of members referred by PCPs or otherwise identified to the CONTRACTOR as potentially in need of Tennessee Health Link services and shall contact and offer such services to all members who meet medical necessity criteria.
- 4. **Section 2.7.2.8.3 and Section 2.7.4.1.7 shall be deleted and replaced as follows:**
 - 2.7.2.8.3 The CONTRACTOR shall monitor behavioral health crisis services and report information to TENNCARE upon request.
 - 2.7.4.1.7 Self-care training, including self-examination;
- 5. **Section 2.7.4.2 shall be amended by adding a new Section 2.7.4.2.3 as follows:**
 - 2.7.4.2.3 The CONTRACTOR shall submit a monthly report that includes the number of EPSDT screening claims processed for service dates beginning with the current federal fiscal year (October 1) through the last day of the current month. This report shall be due by the 20th day after the end of the reporting month.
- 6. **Sections 2.8.4.3.2 and 2.8.4.5.1 shall be amended by deleting and replacing the reference to "NCQA standard QI 8" with the reference "NCQA standard QI 6".**



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7. Sections 2.8.4.7.2 and 2.8.4.7.3 shall be amended by deleting and replacing the reference to "NCQA standard QI 7" with the reference "NCQA standard QI 5".
8. Section 2.8.6 shall be amended by deleting and replacing the reference to "NCQA QI 9" with the reference "NCQA QI 7".
9. **Section 2.12.9.36 shall be amended as follows:**
 - 2.12.9.36 Require that the provider comply with the Affordable Care Act and TennCare policy and procedures, including but not limited to, reporting overpayments, the requirement to report provider initiated refunds of overpayments to the CONTRACTOR and TennCare Office of Program Integrity (OPI) and, when it is applicable, return overpayments to the CONTRACTOR within sixty (60) days from the date the overpayment is identified. Overpayments that are not returned within sixty (60) days from the date the overpayment was identified may be a violation of state or federal law;
10. **Section 2.13.1.2.9 through 2.13.1.2.9.5 shall be amended as follows:**
 - 2.13.1.2.9 The CONTRACTOR agrees to implement retrospective episode based reimbursement and Primary Care Transformation strategies, inclusive of PCMH and Tennessee Health Link, consistent with Tennessee's multi-payer payment reform initiative in a manner and on a timeline approved by TENNCARE. This includes:
 - 2.13.1.2.9.1 Using a retrospective administrative process to reward cost and quality outcomes for the initiative's payment reform strategies that is aligned with the models designed by TENNCARE;
 - 2.13.1.2.9.2 Implementing key design choices as directed by TENNCARE, including the definition of each episode, and the definition of quality measures for the initiative's payment reform strategies;
 - 2.13.1.2.9.3 Delivering performance reports for the initiative's payment reform strategies with the same appearance and content as those designed by the State/Payer Coalition;
 - 2.13.1.2.9.4 Implementation of payment reform strategies at a pace dictated by the State. For episodes this is approximately three to six (3-6) new episodes per quarter with appropriate lead time to allow payer and provider contracting. For PCMH this includes annual waves beginning January 1, 2017 of twenty to seventy-five (20-75) new primary care practices with appropriate lead time to allow payer and provider contracting;
 - 2.13.1.2.9.5 Participate in a State-led process to design and launch the initiative's payment reform strategies, including the seeking of clinical input from payer medical teams and clinical leaders throughout Tennessee for the development of new episodes.



- 11. Section 2.13.1.2.10 shall be amended by adding a new Section 2.13.1.2.10.1 which shall read as follows:

2.13.1.2.10.1 The CONTRACTOR shall not retroactively adjust payments made to an out of network provider due to budget reductions unless approved by TENNCARE.

- 12. Section 2.13.8 shall be amended as follows:

2.13.8 Local Health Departments

2.13.8.1 The CONTRACTOR shall reimburse contracted local health departments (see Sections 2.11.8.3 and 2.12.13) for TennCare Kids screenings to members under age twenty-one (21) at the following rates, unless specified otherwise by TENNCARE. Although the codes include preventive visits for individuals twenty-one (21) and older, this Section only requires the CONTRACTOR to pay local health departments for the specified visits for members under age twenty-one (21).

Preventive Visits	85% of 2001 Medicare
99381 New pt. Up to 1 yr.	\$80.33
99382 New pt. 1 - 4 yrs.	\$88.06
99383 New pt. 5 - 11yrs.	\$86.60
99384 New pt. 12 - 17yrs.	\$95.39
99385 New pt. 18 - 39 yrs.	\$93.93
99391 Estab. pt. Up to 1 yr.	\$63.04
99392 Estab. pt. 1 - 4 yrs.	\$71.55
99393 Estab. pt. 5 - 11yrs.	\$70.96
99394 Estab. pt. 12 - 17yrs.	\$79.57
99395 Estab. pt. 18 - 39 yrs.	\$78.99

2.13.8.2 The CONTRACTOR shall recognize that public health nurses employed by the local health departments are appropriately trained and practice within a scope of protocols developed by the state. The protocols allow public health nurses from across the licensure spectrum to provide services specific to diagnosis, treatment and delivery of preventive services under the general, but not necessarily onsite, supervision of a physician. These services include, but may not be limited to, EPSDT services for children, immunizations, family planning and sexually transmitted disease treatment. TennCare is a state operated program and is not bound by Medicare policy regarding the interpretation of billing codes, therefore, in accordance with the training and protocols the state's public health nurses practice within, the CONTRACTOR shall allow public health nurses to bill using the same CPT codes, related to the aforementioned services, as would be used if the service was delivered by an advance practice nurse.

2.13.8.3 TENNCARE may conduct an audit of the CONTRACTOR's reimbursement methodology and related processes on an annual basis to verify compliance with this requirement. In addition, the Local Health Department may initiate the independent review procedure at any time it believes the CONTRACTOR's payment is not the required reimbursement rate or that the CONTRACTOR has denied claims inappropriately.



mendment 40 (cont.)

13. **Section 2.15.4 shall be deleted and replaced as follows:**

2.15.4 Clinical Practice Guidelines

The CONTRACTOR shall utilize evidence-based clinical practice guidelines in its Population Health Programs (see Section 2.8.7 of this Contract). The guidelines shall be reviewed and revised whenever the guidelines change and at least every two (2) years. The CONTRACTOR shall provide copies of clinical practice guidelines to enrollees upon request. The CONTRACTOR is required to maintain an archive of its clinical practice guidelines for a period of five (5) years. Such archive shall contain each clinical guideline as originally issued so that the actual guidelines for prior years are retained for Program Integrity purposes.

14. **Section 2.15.7 shall be amended by amending Sections A.2.15.7.1.1 and A.2.15.7.1.5, adding new Sections 2.15.7.1.6, 2.15.7.2.2 through 2.15.7.2.4, and 2.15.7.3.3; deleting and replacing 2.15.7.4 as follows; and deleting Section 2.15.7.5 in its entirety and renumbering remaining Sections accordingly, including any references thereto.**

- 2.15.7.1.1 The CONTRACTOR shall develop and implement a critical incident reporting and management system for incidents that occur in a home and community-based long-term services and supports service delivery setting, including: community-based residential alternatives; adult day care centers; other CHOICES HCBS provider sites; and a member's home or any other community-based setting. Critical incidents shall include incidents that occur during the provision of covered CHOICES HCBS and incidents that are discovered or witnessed by the CONTRACTOR, provider, or FEA staff.
- 2.15.7.1.5 In the manner required by TENNCARE, within twenty-four (24) hours of detection or notification, the CONTRACTOR must report to TENNCARE any unexpected death and any incident reported to APS..
- 2.15.7.1.6 As specified in Section 2.30.12.8, the CONTRACTOR shall submit quarterly reports to TENNCARE regarding CHOICES HCBS critical incidents.
- 2.15.7.2.2 The CONTRACTOR's staff and contract providers shall report adverse occurrences to the CONTRACTOR in accordance with applicable requirements. The maximum timeframe for reporting an adverse occurrence to the CONTRACTOR shall be twenty-four (24) hours.
- 2.15.7.2.3 In the manner prescribed by TENNCARE, within twenty-four (24) hours of detection or notification, the CONTRACTOR must report to TENNCARE any adverse occurrence as described above.
- 2.15.7.2.4 As specified in Section 2.30.12.10, the CONTRACTOR shall submit quarterly reports to TENNCARE regarding adverse occurrences.
- 2.15.7.3.3 As specified in Section 2.30.12.12, the CONTRACTOR shall submit quarterly reports to TENNCARE regarding HHA critical incidents.



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- 2.15.7.4 Death of Member Reporting (Not Otherwise Reported in accordance with Section 2.15.7)
 - 2.15.7.4.1 The CONTRACTOR shall report to TENNCARE any unexpected death of a member age twenty-one (21) and older and all deaths of members under age twenty-one (21) that are not otherwise reported in accordance with Section 2.15.7.
 - 2.15.7.4.2 Each incident must be reported using the TENNCARE prescribed MCO Death of Member template within twenty-four (24) business hours of the CONTRACTOR's QM/QI Program staff receiving information relative to such an incident. An updated report, including results of investigation and next steps must be submitted to TENNCARE within thirty (30) calendar days of notification of the incident. The CONTRACTOR shall be responsible, as part of its critical incident management system, to track, review and analyze critical incident data.
15. **Section 2.17.2.2 and 2.17.2.4 shall be deleted and replaced as follows:**
- 2.17.2.2 All written materials shall be clearly legible and unless otherwise directed by TENNCARE, must be written with a minimum font size of 12pt. with the exception of member I.D. cards and certain taglines that require a minimum font size of 18 pt. Any request from the CONTRACTOR for an exception to the written materials font size requirements shall be approved in writing by TENNCARE prior to use;
 - 2.17.2.4 All written materials shall be printed with the notice of non-discrimination and taglines as required by TENNCARE and set forth in TENNCARE's tagline template.
16. **Section 2.17.4.7.18 shall be deleted and replaced as follows:**
- 2.17.4.7.18 Shall include information about the civil rights laws as directed by TENNCARE, which shall include, but is not limited to the notice of nondiscrimination, taglines, and the discrimination complaint forms;
17. **Section 2.17.5.3 shall be amended by deleting and replacing Section 2.17.5.3.2 as follows, deleting Section 2.17.5.3.3 in its entirety, and renumbering the remaining Section accordingly, including any references thereto.**
- 2.17.5.3.2 The procedure on how to obtain information in alternative communication formats, such as auxiliary aids or services and how to access language assistance services (i.e., interpretation and translation services) as well as a statement that interpretation and translation services and auxiliary aids or services are free. The notice of non-discrimination and taglines as required by TENNCARE shall be set forth in TENNCARE's tagline template;
18. **Section 2.17.7.3.8 shall be deleted and replaced as follows:**
- 2.17.7.3.8 The procedure on how to obtain member materials in alternative formats for members with special needs and how to access oral interpretation services and that both alternative formats and interpretation services are available at no expense to the member. The notice of non-discrimination and taglines as required by TENNCARE shall be set forth in TENNCARE's tagline template;



endment 40 (cont.)

19. **Section 2.18.5.3 shall be amended by adding a new Section 2.18.5.3.26 as follows:**
 - 2.18.5.3.26 Information about the civil rights laws as directed by TENNCARE, which shall include, but is not limited to the notice of nondiscrimination, taglines, and the discrimination complaint forms.
20. **Sections 2.20.1 through 2.20.1.9 shall be deleted and replaced as follows and all reference changes shall be amended accordingly.**

2.20.1 General

- 2.20.1.1 The Tennessee Bureau of Investigation, Medicaid Fraud Control Unit (TBI MFCU) is the state agency responsible for the investigation of provider fraud and abuse in the TennCare program.
- 2.20.1.2 The Office of Inspector General (OIG) has the primary responsibility to investigate TennCare enrollee fraud and abuse.
- 2.20.1.3 The CONTRACTOR shall establish written policies and procedures for its employees, subcontractors, providers, and agents that provide detailed information about the False Claims Act, including whistleblower protections, administrative remedies for false claims, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs. The CONTRACTOR shall include in any employee handbook a description of the laws and the rights of employees to be protected as whistleblowers.
- 2.20.1.4 The CONTRACTOR shall have surveillance and utilization control programs and procedures (42 CFR 456.3, 456.4, 456.23) to safeguard the Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments. The CONTRACTOR shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities.
- 2.20.1.5 The CONTRACTOR, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 CFR Part 455) on disclosure reporting. All tax-reporting provider entities that bill and/or receive TennCare funds as the result of this Contract shall submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B and TennCare policies and procedures, including at the time of initial contracting, contract renewal, at any time there is a change to any of the information on the disclosure form, at least once every three (3) years, and at any time upon request.



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- 2.20.1.6 The CONTRACTOR, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 C.F.R. § 1002) on exclusion and debarment screening. The CONTRACTOR, its subcontractors and all tax-reporting provider entities that bill and/or receive TennCare funds as the result of this Contract shall screen their owners and employees against the Excluded Parties List System (EPLS) and the HHS-OIG List of Excluded Individuals/Entities (LEIE). In addition, the CONTRACTOR and its subcontractors shall screen their owners and employees against the Social Security Master Death File. Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by the State.
- 2.20.1.7 The CONTRACTOR shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the CONTRACTOR in preventing and detecting potential fraud and abuse activities.
- 2.20.1.8 The CONTRACTOR is prohibited from taking any actions to recoup or withhold improperly paid funds already paid or potentially due to a provider when the issues, services or claims upon which the recoupment or withhold are based meet one or more of the following criteria:
 - 2.20.1.8.1 The improperly paid funds have already been recovered by the State of Tennessee, either by TENNCARE directly or as part of a resolution of a state or federal investigation and/or lawsuit, including but not limited to False Claims Act cases; or
 - 2.20.1.8.2 The improperly paid funds have already been recovered by the States Recovery Audit Contractor (RAC) contractor; or
 - 2.20.1.8.3 When the issues, services or claims that are the basis of the recoupment or withhold are currently being investigated by the State of Tennessee, are the subject of pending Federal or State litigation or investigation, or are being audited by the TennCare RAC.
 - 2.20.1.8.4 The prohibition described in this section shall be limited to a specific provider(s), for specific dates, and for specific issues, services, or claims.
 - 2.20.1.8.5 To determine whether this prohibition may apply to the CONTRACTOR's actions, the CONTRACTOR shall:
 - 2.20.1.8.5.1 Check the most recent Provider Alert List (PAL) from TennCare OPI for each relevant provider and provider NPI; and
 - 2.20.1.8.5.2 Contact TennCare OPI if a relevant provider or provider NPI is on the PAL to determine the specific dates, issues, services, or claims covered by the prohibition.
 - 2.20.1.8.6 In the event that CONTRACTOR obtains funds in cases where repayment is prohibited under this section, the CONTRACTOR will notify the Director of TennCare OPI and take action in accordance with written instructions from the Director of TennCare OPI.



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- 2.20.1.8.7 If the CONTRACTOR fails to adhere to the prohibitions and requirements of this section, the CONTRACTOR may be subject to forfeiture of the funds to the State and the imposition of liquidated damages as described in Section E.29.2.
- 2.20.1.9 If a provider offers or initiates a voluntary refund to the CONTRACTOR of an overpayment of funds, the CONTRACTOR shall:
 - 2.20.1.9.1 Determine whether the provider or provider NPI is under investigation, or is subject to a claim tag from the State of Tennessee or from the State's RAC;
 - 2.20.1.9.1.1 Check the most recent PAL from TennCare OPI for each relevant provider or provider NPI, and
 - 2.20.1.9.1.2 Contact TennCare OPI if a relevant provider or provider NPI is on the PAL to determine the specific dates, issues, services, or claims that are under investigation or subject to claim tag.
 - 2.20.1.9.2 In the event a provider offers or initiates a voluntary refund of funds associated with dates, issues, services, or claims which are under investigation, or subject to a claim tag, the CONTRACTOR shall take action in accordance with written instructions from the Director of TennCare OPI.
 - 2.20.1.9.3 If TennCare OPI determines that funds obtained by a CONTRACTOR through a voluntary refund initiated by a provider are under investigation or subject to a claim tag, the CONTRACTOR shall segregate and hold separate the funds until OPI notifies the CONTRACTOR of a resolution of the investigation or claim tag. The CONTRACTOR shall not amend the claims associated with the funds submitted through a voluntary refund by the provider without written approval from TennCare OPI.
 - 2.20.1.9.4 If the CONTRACTOR fails to adhere to the requirements of this section, or take action in accordance with written instructions from the Director of TennCare OPI, the CONTRACTOR may be subject to forfeiture of the funds to the State and the imposition of liquidated damages, as described in E.29.2.
- 2.20.1.10 The CONTRACTOR shall comply with all federal and state requirements regarding fraud and abuse, including but not limited to Sections 1128, 1156, and 1902(a)(68) of the Social Security Act.



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21. **Section 2.20.2 shall be amended by adding a new Section 2.20.2.10, renumbering the remaining Section accordingly, including any references thereto, and deleting and replacing the renumbered Section 2.20.17 as follows:**

- 2.20.2.10 The CONTRACTOR shall suspend payment to a provider upon notification from TennCare OPI of the determination of a credible allegation of fraud.
- 2.20.2.17 In accordance with the Affordable Care Act and TennCare policy and procedures, the CONTRACTOR shall promptly report overpayments made by TENNCARE to the CONTRACTOR as well as overpayments made by the CONTRACTOR to a provider and/or subcontractor (See Section 2.12.9.42).

22. **Section 2.22.8.1.7 shall be amended as follows:**

- 2.22.8.1.7 Provider validation: the system shall approve for payment only those claims received from providers eligible to render services for which the claim was submitted, including requirements related to public health nurses as described in Section 2.13.7.2; and

23. **Section 2.30.4 shall be deleted and replaced as follows:**

2.30.4 Specialized Service Reports

- 2.30.4.1 The CONTRACTOR shall submit a quarterly *Psychiatric Hospital/RTF Readmission Report* that provides: the percentage of members readmitted to the facility within seven (7) calendar days of discharge (the number of members readmitted divided by the total number of discharges); the percent of members readmitted within thirty (30) calendar days of discharge (the number of members readmitted divided by the total number of discharges); and an analysis of the findings with any actions or follow-up planned. The information shall be reported separately for members age eighteen (18) and over and under eighteen (18).
- 2.30.4.2 The CONTRACTOR shall submit a quarterly *Post-Discharge Services Report* that provides information on Post-Discharge services appointments. The minimum data elements required are identified in Attachment IX, Exhibit B.
- 2.30.4.3 The CONTRACTOR shall submit a quarterly *Behavioral Crisis Prevention, Intervention, and Stabilization Services for Individuals with Intellectual or Developmental Disabilities (I/DD) Report* including the data elements described by TENNCARE. Specified data elements shall be reported for each individual provider as described in the template provided by TENNCARE.
- 2.30.4.4 The CONTRACTOR shall submit a quarterly *Tennessee Health Link (THL) Report* including the data elements described by TENNCARE. Specified data elements shall be reported for each individual provider as described in the template provided by TENNCARE.
- 2.30.4.5 The CONTRACTOR shall submit annually, a *Tennessee Health Link (THL) Audit Report* including the data elements described by TENNCARE.



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2.30.4.6 The CONTRACTOR shall submit a *TennCare Kids Quarterly Outreach Activities Report* which shall be in a format designated by TENNCARE and shall include a listing of related and non-related TennCare Kids events.

2.30.4.7 The CONTRACTOR shall submit a *Monthly EPSDT Claims Report*, which shall include the number of EPSDT screening claims processed by region for the service dates beginning with the current federal fiscal year (October 1) through the last day of the current month. This report shall be due by the 20th day after the end of the reporting month.

24. **Section 2.30.12.8 through 2.30.12.11 shall be deleted and replaced as follows:**

2.30.12.8 Upon enrollment of members in CHOICES Group 2 and/or 3 (if and when directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3), the CONTRACTOR shall submit a quarterly *CHOICES HCBS Critical Incidents Report* (see Section 2.15.7). MFP participants (see 2.9.8) shall be identified separately for each data element described herein. The report shall provide information, by month regarding specified measures, which shall include but not be limited to the following:

2.30.12.8.1 The number of members in CHOICES Group 2, Group 3, and CHOICES Groups 2 and 3 combined

2.30.12.8.2 The number of critical incidents, overall and by:

2.30.12.8.2.1 Type of incident

2.30.12.8.2.2 Setting

2.30.12.8.2.3 Type of provider (provider agency or consumer-directed worker)

2.30.12.8.3 The percent of incidents by type of incident

2.30.12.8.4 The percent of members in CHOICES Groups 2 and 3 with an incident

2.30.12.9 LEFT BLANK INTENTIONALLY

2.30.12.10 The CONTRACTOR shall submit a quarterly *Behavioral Health Adverse Occurrences Report* in accordance with Section 2.15.7.2 that provides information, by month regarding specified measures, which shall include but not be limited to the following:

2.30.12.10.1 The number of adverse occurrences, overall and by:

2.30.12.10.1.1 Date of occurrence;

2.30.12.10.1.2 Type of adverse occurrence;

2.30.12.10.1.3 Location;

2.30.12.10.1.4 Provider name; and



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- 2.30.12.10.1.5 Action Taken by Facility/Provider.
- 2.30.12.11 LEFT BLANK INTENTIONALLY
- 2.30.12.12 The CONTRACTOR shall submit a quarterly *Home Health Critical Incident Report* in accordance with Section 2.15.7.3 that provides information, by month regarding specified measures, which shall include but not be limited to the following:
 - 2.30.12.12.1 The number of Critical Incidents, overall and by:
 - 2.30.12.12.1.1 Date of Critical Incident;
 - 2.30.12.12.1.2 Type of Critical Incident;
 - 2.30.12.12.1.3 Location;
 - 2.30.12.12.1.4 Provider name; and
 - 2.30.12.12.1.5 Action Taken by Facility/Provider.
- 25. **Section 2.30.22.4.2 shall be amended by deleting and replacing the due date of “December 15” to “February 1”.**
- 26. **Section 4.10.1 shall be amended as follows:**
 - 4.10.1 In no event shall the maximum liability of the State under this Agreement during the original term of the Contract exceed Four Billion, Eight Hundred Million, Five Hundred Twenty Three Thousand, Five Hundred Five Dollars and Ninety Cents (\$4,800,523,505.90).
- 27. **Section 5.2.1 shall be amended by deleting the reference to “December 31, 2016” and replacing it with “December 31, 2017”.**
- 28. **Section 5.3 shall be amended by adding a new Section 5.3.50 as follows:**
 - 5.3.50 Section 1914 of Title XIX of the Social Security Act and 42 CFR §447.30.
- 29. **Attachment I shall be deleted and replaced as follows:**

**ATTACHMENT I
BEHAVIORAL HEALTH SPECIALIZED SERVICE DESCRIPTIONS**

The CONTRACTOR shall provide medically necessary Behavioral Health Intensive Community Based Treatment Services, Tennessee Health Link, and psychiatric rehabilitation services according to the requirements herein.

All behavioral health services shall be rendered in a manner that supports the recovery of persons experiencing mental illness and enhance the development of resiliency of children and families who are impacted by mental illness, serious emotional disturbance, and/or substance use disorders. Recovery is a consumer driven process in which consumers are able to work, learn and participate fully in their communities. Recovery is the ability to live a fulfilling and productive life with a disability.



SERVICE	Behavioral Health Intensive Community Based Treatment Services
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DEFINITION

Behavioral Health Intensive Community Based Treatment (ICBT) Services provide frequent and comprehensive support to individuals with a focus on recovery and resilience. The CONTRACTOR shall ensure the provision of Behavioral Health Intensive Community Based Treatment Services to adults and youth with complex needs including individuals who are at high risk of future hospitalization or placement out of the home and require both community support and treatment interventions. Behavioral Health Intensive Community Based Treatment Services shall be rendered through a team approach which shall include a therapist and care coordinator who work under the direct clinical supervision of a licensed behavioral health professional. The primary goal of these services is to reach an appropriate point of therapeutic stabilization so the individual can be transitioned to less in home based services and be engaged in appropriate behavioral health office based services.

Intensive Community Based Treatment Services should include, at a minimum, the following elements and services as clinically appropriate:

- System Of Care principles
- Certified Family Support Specialist services
- Direct clinical supervision
- Evidenced-based comprehensive assessments and evaluations
- Minimum of one to two (1-2) visits per week for individual therapy, family therapy, or family support from a Certified Family Support Specialist

Intensive Community Based Treatment Services shall be outcome-driven, including, but not limited to these treatment outcomes:

- Strengthened family engagement in treatment services
- Increased collaboration among formal and informal service providers to maximize therapeutic benefits
- Progress toward child & family goals
- Increased positive coping skills
- Increased family involvement in the community
- Developed skills to independently navigate the behavioral health system

Intensive Community Based Treatment Services include CTT, CCFT, and PACT treatment models as described below:

Continuous Treatment Team (CTT)

CTT is a coordinated team of staff (to include physicians, nurses, case managers, and other therapists as needed) who provide a range of intensive, care coordination, treatment, and rehabilitation services to adults and children and youth. The intent is to provide intensive treatment to adults and families of children and youth with acute psychiatric problems in an effort to prevent removal from the home to a more restrictive level of care. An array of services are delivered in the home or in natural settings in the community, and are provided through a strong partnership with the family and other community support systems. The program provides services including crisis intervention and stabilization, counseling, skills building, therapeutic intervention, advocacy, educational services, medication management as indicated, school based counseling and consultation with teachers, and other behavioral health services deemed necessary and appropriate.



Comprehensive Child and Family Treatment (CCFT)

CCFT services are high intensity, time-limited, therapeutic services designed for children and youth to provide stabilization and deter from out-of-home placement. There is usually family instability and high-risk behaviors exhibited by the child/adolescent. CCFT services are concentrated on child, family, and parental/guardian behaviors and interaction. CCFT services are more treatment oriented and situation specific with a focus on short-term stabilization goals.

Program of Assertive and Community Treatment (PACT)

PACT is a service delivery model for providing comprehensive community-based treatment to adults with severe and persistent mental illness. It involves the use of a multi-disciplinary team of mental health staff organized as an accountable, mobile mental health agency or group of providers who function as a team interchangeably to provide the treatment, rehabilitation and support services persons with severe and/or persistent mental illnesses need to live successfully in the community. The service components of PACT include:

- 1) Services targeted to a specific group of individuals with severe mental illness;
- 2) Treatment, support and rehabilitation services provided directly by the PACT team;
- 3) Sharing of responsibility between team members and individuals served by the team;
- 4) Small staff (all team staff including case managers) to individual ratios (approx. 1 to 10);
- 5) Comprehensive and flexible range of treatment and services;
- 6) Interventions occurring in community settings rather than in hospitals or clinic settings;
- 7) Twenty-four (24) hour a day availability of services; and
- 8) Engagement of individuals in treatment and recovery.

SERVICE	Tennessee Health Link
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DEFINITION

Tennessee Health Link is a team of professionals associated with a mental health clinic or other behavioral health provider who provides whole-person, patient-centered, coordinated care for an assigned panel of members with behavioral health conditions. Members who would benefit from Tennessee Health Link will be identified based on diagnosis, health care utilization patterns, or functional need. They will be identified through a combination of claims analysis and provider referral.

Health Link professionals will use care coordination and patient engagement techniques to help members manage their healthcare across the domains of behavioral and physical health, including:

- Comprehensive care management (e.g., creating care coordination and treatment plans)
- Care coordination (e.g., proactive outreach and follow up with primary care and behavioral health providers)
- Health promotion (e.g., educating the patient and his/her family on independent living skills)
- Transitional care (e.g., participating in the development of discharge plans)
- Patient and family support (e.g., supporting adherence to behavioral and physical health treatment)
- Referral to social supports (e.g., facilitating access to community supports including scheduling and follow through)



SERVICE

Psychiatric Rehabilitation

DEFINITION

Psychiatric rehabilitation is an array of consumer-centered recovery services designed to support the individual in the attainment or maintenance of his or her optimal level of functioning. These services are designed to capitalize on personal strengths, develop coping skills and strategies to deal with deficits and develop a supportive environment in which to function as independent as possible on the individual's recovery journey.

The service components included under psychiatric rehabilitation are as follows:

Psychosocial Rehabilitation

Psychosocial Rehabilitation is a community-based program that promotes recovery, community integration, and improved quality of life for members who have been diagnosed with a behavioral health condition that significantly impairs their ability to lead meaningful lives. The goal of Psychosocial Rehabilitation is to support individuals as active and productive members of their communities through interventions developed with a behavioral health professional or certified peer recovery specialist, in a non-residential setting. These interventions are aimed at actively engaging the member in services, and forming individualized service plan goals that will result in measurable outcomes in the areas of educational, vocational, recreational and social support, as well as developing structure and skills training related to activities of daily living. Such interventions are collaborative, person-centered, individualized, and ultimately results in the member's wellness and recovery being sustainable within the community without requiring the support of Psychosocial Rehabilitation. Psychosocial Rehabilitation must meet medical necessity criteria and may be provided in conjunction with routine outpatient services.

Psychosocial Rehabilitation services vary in intensity, frequency, and duration in order to resolve the member's ability to manage functional difficulties.

Supported Employment

Supported employment consists of evidenced based practices (e.g., individual placement and support) to assist individuals to choose, prepare for, obtain, and maintain gainful employment that is based on individuals' preferences, strengths, and experiences. This service also includes support services to the individual, including side-by-side support on the job. These services may be integrated into a psychosocial rehabilitation center.

Peer Recovery Services

Peer recovery services are designed and delivered by people who have lived experience with behavioral health issues. A Certified Peer Recovery Specialist (CPRS) is someone who has self-identified as being in recovery from mental illness, substance use disorder, or co-occurring disorders of both mental illness and substance use disorder. In addition, a Certified Peer Recovery Specialist has completed specialized training recognized by the Tennessee Department of Mental Health and Substance Abuse Services on how to provide peer recovery services based on the principles of recovery and resiliency. Certified Peer Recovery Specialists can provide support to others with mental illness, substance use disorder, or co-occurring disorder and help them achieve their personal recovery goals by promoting self-determination, personal responsibility, and the empowerment inherent in self-directed recovery.



ment 40 (cont.)

Under the direct clinical supervision of a licensed behavioral health professional, peer recovery services provided by a Certified Peer Recovery Specialist may include: assisting individuals in the development of a strengths-based, person-centered plan of care; serving as an advocate or mentor; developing community support; and providing information on how to successfully navigate the behavioral health care system. Activities which promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills are provided so individuals can educate and support each other in the acquisition of skills needed to manage their recovery and access resources within their communities. Services are often provided during the evening and weekend hours.

Family Support Services

Family support services are used to assist other caregivers of children or youth diagnosed with emotional, behavioral, or co-occurring disorders, and are provided by a Certified Family Support Specialist under the direct clinical supervision of a licensed behavioral health professional. A Certified Family Support Specialist is a person who has previously self-identified as the caregiver of a child or youth with an emotional, behavioral or co-occurring disorder and who has successfully navigated the child-serving systems to access treatment and resources necessary to build resiliency and foster success in the home, school, and community. This individual has successfully completed and passed training recognized by the Tennessee Department of Mental Health and Substance Abuse Services on how to assist other caregivers in fostering resiliency in their child based on the principles of resiliency and recovery; and has received certification from the Tennessee Department of Mental Health and Substance Abuse Services as a Certified Family Support Specialist.

These services include assisting caregivers in managing their child's illness and fostering resiliency and hope in the recovery process. These direct caregiver-to-caregiver support services include, but are not limited to, developing formal and informal supports, assisting in the development of strengths-based family and individual goals, serving as an advocate, mentor, or facilitator for resolution of issues that a caregiver is unable to resolve on his or her own, or providing education on system navigation and skills necessary to maintain a child with emotional, behavioral or co-occurring disorders in their home environment.

Illness Management & Recovery

Illness management and recovery services refer to a series of weekly sessions with trained mental health practitioners for the purpose of assisting individuals in developing personal strategies for coping with mental illness and promoting recovery. Illness management and recovery is not limited to one curriculum but is open to all evidenced-based and/or best practice classes and programs such as WRAP (Wellness Recovery Action Plan).

Supported Housing

Supported housing services refer to transitional services rendered at facilities that provide behavioral health staff supports for individuals who require treatment services in a highly structured, safe, and secure setting. Supported housing services are for TennCare Priority Enrollees and are intended to prepare individuals to live independently in a community setting. At a minimum, supported housing services include coordinated and structured personal care services to address the individuals' behavioral and physical health needs in addition to fifteen (15) hours per week of psychosocial rehabilitation services to assist individuals in achieving recovery and resiliency based goals and developing the life skills necessary to live independently in a community setting. The required fifteen (15) hours per week of psychosocial rehabilitation is not inclusive of the psychosocial rehabilitation services received in day programs. Supported housing services do not include the payment of room and board.



SERVICE

Crisis Services

Definition

Behavioral health crisis services shall be rendered to individuals with a mental health or substance use/abuse issue when there is a perception of a crisis by an individual, family member, law enforcement, hospital staff or others who have closely observed the individual experiencing the crisis. Crisis services are available twenty-four (24) hours a day, seven (7) days a week. Crisis services include twenty-four (24) hour toll free telephone lines answered in real time by trained crisis specialists and face-to-face crisis services including, but not limited to: prevention, triage, intervention, evaluation/referral for additional services/treatment, and follow-up services. Certified Peer Recovery Specialists and/or Certified Family Support Specialists shall be utilized in conjunction with crisis specialists to assist adults and children in alleviating and stabilizing crises and promote the recovery process as appropriate. Behavioral health crisis service providers are not responsible for pre-authorizing emergency involuntary hospitalizations.

The Mental Health Crisis Response Services - Community Face-to-Face Response Protocols provide guidance for calls that are the responsibility of a crisis response service to determine if a Face-to-Face evaluation is warranted and those that are not the responsibility of the crisis response service. These Protocols were developed to ensure that consumers who are experiencing a behavioral health crisis and have no other resources receive prompt attention. All responses are first determined by clinical judgment.

Guidance for All Calls:

- For calls originating from an Emergency Dept., telehealth is the preferred service delivery method for the crisis response service
- After determining that there is no immediate harm, ask the person if he or she can come to the closest walk-in center
- If a Mandatory Pre-screening Agent (MPA) not employed by a crisis response service is available, there may be no need for a crisis evaluation by mobile crisis
- For all other calls, unless specified in the Protocols, if a person with mental illness is experiencing the likelihood of immediate harm then a response is indicated.

30. **The Service Charts in Attachment V shall be amended by deleting and replacing “Mental Health Case Management” with “Intensive Community Based Treatment Services” and adding “Tennessee Health Link Services” as follows:**

**ATTACHMENT V
ACCESS & AVAILABILITY FOR BEHAVIORAL HEALTH SERVICES**

The CONTRACTOR shall adhere to the following behavioral health network requirements to ensure access and availability to behavioral health services for all members (adults and children). For the purpose of assessing behavioral health provider network adequacy, TENNCARE will evaluate the CONTRACTOR’s provider network relative to the requirements described below. Providers serving adults will be evaluated separately from those serving children.

Access to Behavioral Health Services

The CONTRACTOR shall ensure access to behavioral health providers for the provision of covered services. At a minimum, this means that:



nendment 40 (cont.)

The CONTRACTOR shall have provider agreements with providers of the services listed in the table below and meet the geographic **and** time for admission/appointment requirements.

Service Type	Geographic Access Requirement	Maximum Time for Admission/ Appointment
Psychiatric Inpatient Hospital Services	Travel distance does not exceed 90 miles for at least 90% of members	4 hours (emergency involuntary)/24 hours (involuntary)/24 hours (voluntary)
24 Hour Psychiatric Residential Treatment	<p>The CONTRACTOR shall contract with at least 1 provider of service in each Grand Region (3 statewide) for ADULT members</p> <p>-----</p> <p>-----</p> <p>Travel distance does not exceed 60 miles for at least 75% of CHILD members and does not exceed 90 miles for at least 90% of CHILD members</p>	Within 30 calendar days
Outpatient Non-MD Services	Travel distance does not exceed 30 miles for ALL members	Within 10 business days; if urgent, within 48 hours
Intensive Outpatient (may include Day Treatment (adult), Intensive Day Treatment (Children & Adolescent) or Partial Hospitalization)	Travel distance does not exceed 90 miles for at least 90% of members	Within 10 business days; if urgent, within 48 hours
Inpatient Facility Services (Substance Abuse)	Travel distance does not exceed 90 miles for at least 90% of members	Within 2 calendar days; for detoxification - within 4 hours in an emergency and 24 hours for non-emergency
24 Hour Residential Treatment Services (Substance Abuse)	<p>The CONTRACTOR shall contract with at least 1 provider of service in each Grand Region (3 statewide) for ADULT members</p> <p>-----</p> <p>The CONTRACTOR shall contract with at least 1 provider of service in each Grand Region (3 statewide) for CHILD members</p>	Within 10 business days
Outpatient Treatment Services (Substance Abuse)	Travel distance does not exceed 30 miles for ALL members	Within 10 business days; for detoxification – within 24 hours
Intensive Community Based Treatment Services	Not subject to geographic access standards	Within 7 calendar days
Tennessee Health Link Services	Not subject to geographic access standards	Within 30 Calendar Days



ment 40 (cont.)

Psychosocial Rehabilitation (may include Supported Employment, Illness Management & Recovery, Peer Recovery services or Family Support service)	Not subject to geographic access standards	Within 10 business days
Supported Housing	Not subject to geographic access standards	Within 30 calendar days
Crisis Services (Mobile)	Not subject to geographic access standards	Face-to-face contact within 2 hours for emergency situations and 4 hours for urgent situations
Crisis Stabilization	Not subject to geographic access standards	Within 4 hours of referral

TENNCARE will evaluate the need for further action when the above standards are not met. At its sole discretion TENNCARE may elect one of three options: (1) TENNCARE may request a Corrective Action Plan (CAP), (2) a Request for Information (RFI), (3) or an On Request Report (ORR) depending on the severity of the deficiency.

The requested CAP, RFI or ORR response shall detail the CONTRACTOR's network adequacy considering any alternate measures, documentation of unique market conditions and/or its plan for correction. If TENNCARE determines the CONTRACTOR's response demonstrates the existence of alternate measures or unique market conditions, TENNCARE may elect to request periodic updates from the CONTRACTOR regarding efforts to address such conditions.



At a minimum, providers for the following service types shall be reported on the Provider Enrollment File:

Service Type	Service Code(s) for use in position 330-331 of the Provider Enrollment File
Psychiatric Inpatient Hospital Services	Adult - 11, 79, 85 Child - A1 or H9
24 Hour Psychiatric Residential Treatment	Adult - 13, 81, 82 Child - A9, H1, or H2
Outpatient MD Services (Psychiatry)	Adult - 19 Child - B5
Outpatient Non-MD Services	Adult - 20 Child - B6
Intensive Outpatient/ Partial Hospitalization	Adult - 21, 23, 62 Child - B7, C2, C3
Inpatient Facility Services (Substance Abuse)	Adult - 15, 17 Child - A3, A5
24 Hour Residential Treatment Services (Substance Abuse)	Adult - 56 Child - F6
Outpatient Treatment Services (Substance Abuse)	Adult - 27 or 28 Child - D3 or D4
Intensive Community Based Treatment Services	Adult - 66, or 83 Child - C7, G2, G6, or K1
Tennessee Health Link Services	Adult-31 Child-D7
Psychiatric Rehabilitation Services:	
Psychosocial Rehabilitation	42
Supported Employment	44
Peer Recovery Services	88
Family Support Services	49
Illness Management & Recovery	91
Supported Housing	32 and 33
Crisis Services (Mobile)	Adult - 37, 38, 39 Child - D8, D9, E1
Crisis Respite	Adult - 40 Child - E2
Crisis Stabilization	Adult 41



Amendment 40 (cont.)

All of the provisions of the original Contract not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective January 1, 2017.

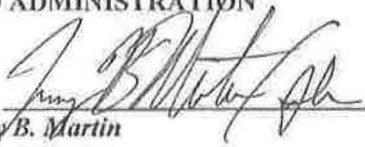
The State is not bound by this Amendment until it is signed by the contract parties and approved by appropriate officials in accordance with applicable Tennessee laws and regulations (depending upon the specifics of this Contract, said officials may include, but are not limited to, the Commissioner of Finance and Administration, the Commissioner of Human Resources, and the Comptroller of the Treasury).

The CONTRACTOR, by signature of this Amendment, hereby affirms that this Amendment has not been altered and therefore represents the identical document that was sent to the CONTRACTOR by TENNCARE.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

VOLUNTEER STATE HEALTH PLAN, INC.

BY: 
Larry B. Martin
Commissioner

BY: 
Amber Cambron
President & CEO VSHP

DATE: 10/24/16

DATE: 10/21/16



CONTRACT AMENDMENT COVER SHEET

Agency Tracking # 31866-00026	Edison ID 29635	Contract #	Amendment # 39
Contractor Legal Entity Name VSHP (TennCare Select)			Edison Vendor ID 0000071694

Amendment Purpose & Effect(s)
Updates Scope – TennCare Managed Care Organization / Medically Necessary Health Care Services

Amendment Changes Contract End Date: YES NO **End Date:** December 31, 2016

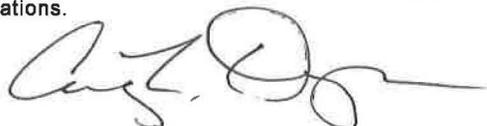
TOTAL Contract Amount INCREASE or DECREASE per this Amendment (zero if N/A): \$ 0.00

Funding —					
FY	State	Federal	Inter-departmental	Other	TOTAL Contract Amount
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$ 18,599,868.48
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$ 33,079,942.80
2004	\$ 25,125,990.72	\$ 38,364,165.90			\$ 63,490,156.62
2005	\$ 58,007,447.00	\$ 58,007,447.00			\$ 116,014,894.00
2006	\$ 87,748,111.00	\$ 87,748,111.00			\$ 175,496,222.00
2007	\$ 87,748,111.00	\$ 87,748,111.00			\$ 175,496,222.00
2008	\$ 72,610,000.00	\$ 127,390,000.00			\$ 200,000,000.00
2009	\$ 72,610,000.00	\$ 127,390,000.00			\$ 200,000,000.00
2010	\$ 100,882,479.00	\$ 304,024,121.00			\$ 404,906,600.00
2011	\$ 131,085,619.00	\$ 312,820,981.00			\$ 443,906,600.00
2012	\$ 149,893,942.00	\$ 294,012,658.00			\$ 443,906,600.00
2013	\$ 150,102,578.00	\$ 293,804,022.00			\$ 443,906,600.00
2014	\$ 153,147,777.00	\$ 290,758,823.00			\$ 443,906,600.00
2015	\$ 155,078,771.00	\$ 288,827,829.00			\$ 443,906,600.00
2016	\$ 155,211,942.69	\$ 288,694,657.31			\$ 443,906,600.00
2017	\$ 77,605,971.34	\$ 144,347,328.66			\$ 221,953,300.00
TOTAL:	\$ 1,499,399,800.38	\$ 2,773,077,005.52			\$ 4,272,476,805.90

American Recovery and Reinvestment Act (ARRA) Funding: YES NO

Budget Officer Confirmation: There is a balance in the appropriation from which obligations hereunder are required to be paid that is not already encumbered to pay other obligations.

CPO USE



Speed Chart (optional)	Account Code (optional)
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**AMENDMENT NUMBER 39
AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.**

CONTRACT NUMBER: FA-02-14632-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as specified below.

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. Sections 2.4.6.3 and 2.23.5.3 shall be deleted and replaced as follows:

- 2.4.6.3 The CONTRACTOR shall provide a daily electronic eligibility file (inbound 834) to TENNCARE as specified and in conformance to data exchange format and method standards outlined in Section 2.23.5.

- 2.23.5.3 The CONTRACTOR shall transmit daily to TENNCARE, in the formats and methods specified in the HIPAA Implementation and TennCare Companion guides or as otherwise specified by TENNCARE: member address changes, telephone number changes, third party liability and PCP.

2. Section 2.7.4.2 through 2.7.4.2.3 shall be deleted and replaced as follows:

- 2.7.4.2 The CONTRACTOR shall submit an Annual Community Outreach Plan no later than December 1 of each year for review and approval by TENNCARE.

- 2.7.4.2.1 The Annual Community Outreach Plan shall be written in accordance with guidance prepared by TENNCARE. It shall include, but is not limited to: all proposed community screening/health education events related to TennCare Kids; all proposed community/health education events unrelated to TennCare Kids; a system for documenting and evaluating events within thirty (30) days of occurrence; and reporting on evaluations in the TennCare Kids Quarterly Updates. A Year-End Update of the Plan shall be due no later than forty-five (45) days following the end of a calendar year in a format approved by TENNCARE. This evaluation must include an appraisal of the objectives in the Plan and an assessment of the events conducted in the previous year in a format approved by TENNCARE.

- 2.7.4.2.1.1 Each plan must include:



Amendment 39 (cont.)

- 2.7.4.2.1.1.1 Methodology for developing the plan to include data assessments conducted, policy and procedure reviews, and any research that may have been conducted.
 - 2.7.4.2.1.1.2 Outreach efforts must include both written and oral communications and must address both rural and urban areas of the state and efforts to reach minorities and other underserved populations.
 - 2.7.4.2.1.1.3 Outreach efforts to teens.
 - 2.7.4.2.1.1.4 Interim evaluation criteria.
 - 2.7.4.2.1.1.5 Annual evaluation criteria.
 - 2.7.4.2.1.2 Each plan must be resubmitted quarterly with updates on progress included.
 - 2.7.4.2.2 A list of community screening events and other health education events, both related and unrelated to TennCare Kids, shall be included in the Quarterly Outreach Activities Report (See Section A.2.30.4.4) in a format specified by TENNCARE. The list must include designation of either TennCare Kids or Other as well as the county in which the event was held.
3. **Section 2.8.4.5 shall be amended by adding a new Section 2.8.4.5.5 as follows and renumbering the remaining Sections accordingly, including any references thereto.**
- 2.8.4.5.5 The CONTRACTOR shall assess the need for a face-to-face visit using the standard assessment criteria provided by TENNCARE for all population health programs requiring interactive interventions.
4. **Sections 2.15.7.3 and 2.15.7.5 shall be deleted and replaced as follows:**
- 2.15.7.3 Home Health Agency Critical Incident Reporting
 - 2.15.7.3.1 The CONTRACTOR shall identify, track, and review all significant critical incidents that occur during the provision of Home Health (HH) services. This requirement shall be applied for all members, including CHOICES and Non-CHOICES members. A HH critical incident shall include those significant incidents that are reported to the CONTRACTOR from the Home Health Agency (HHA). Critical incidents include, but are not limited to, the following:
 - 2.15.7.3.1.1 Any unexpected death, regardless of whether the death occurs during the provision of HH;
 - 2.15.7.3.1.2 Major/severe injury;
 - 2.15.7.3.1.3 Safety issues;
 - 2.15.7.3.1.4 Suspected physical, mental or sexual abuse;
 - 2.15.7.3.1.5 Neglect;
 - 2.15.7.3.1.6 Life-threatening medical emergency;



Amendment 39 (cont.)

2.15.7.3.1.7 Medication error;

2.15.7.3.1.8 Financial exploitation;

2.15.7.3.1.9 Theft.

2.15.7.3.2 Each incident must be reported using the TENNCARE prescribed HHA Critical Incident report template within twenty-four (24) business hours of the CONTRACTOR QM/QI Program staff receiving information relative to such an incident. An updated report, including results of investigation and next steps must be submitted to TENNCARE within thirty (30) calendar days of notification of the incident. The CONTRACTOR shall be responsible, as part of its critical incident management system, to track, review and analyze critical incident data in a manner described in Section A.2.15.7.1.2 that takes into consideration all incidents occurring for members supported by an agency, whether they occur during the provision of CHOICES HCBS or HH services, including the identification of trends and patterns, opportunities for improvement, and actions and strategies the CONTRACTOR will take to reduce the occurrence of incidents and improve the quality of HH services received.

2.15.7.5 As specified in Sections A.2.30.12.8, A.2.30.12.9 and A.2.30.12.10, the CONTRACTOR shall submit quarterly reports to TENNCARE regarding all critical incidents.

5. **Section 2.20.1.5 and 2.20.1.8 shall be deleted and replaced as follows:**

2.20.1.5 The CONTRACTOR, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 C.F.R. § 1002) on exclusion and debarment screening. All tax-reporting provider entities that bill and/or receive TennCare funds as the result of this Contract shall screen their owners and employees against the Social Security Master Death File, the Excluded Parties List System (EPLS) and the HHS-OIG List of Excluded Individuals/Entities (LEIE). Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by the State.

2.20.1.8 This prohibition described above in Section 2.20.1.7 shall be limited to a specific provider(s), for specific dates, and for specific issues, services or claims. The CONTRACTOR shall check with the Bureau of TennCare, Program Integrity Unit before initiating any recoupment or withhold of any program integrity related funds (See Section A.2.20.1.7) to ensure that the recoupment or withhold is permissible. In the event that the CONTRACTOR obtains funds in cases where repayment is prohibited under this section, the CONTRACTOR will notify the Director of Program Integrity and take action in accordance with written instructions from the Director of Program Integrity. If the funds are under investigation by the State of Tennessee or have approved claim tags from the State of Tennessee or approved claim tags by the TennCare RAC then the CONTRACTOR will be subject to forfeiture of the funds to the State and the imposition of liquidated damages.

6. **Section 2.20.2.3 shall be amended by deleting the website link and replacing it as follows:**

2.20.2.3 The CONTRACTOR shall notify TBI MFCU and TennCare Office of Program Integrity simultaneously and in a timely manner regarding all internal (such as identified patterns of data mining outliers, audit concerns, critical incidences) and external (such as hotline



Amendment 39 (cont.)

calls) tips with potential implications to TennCare providers' billing anomalies and/or to safety of TennCare enrollees (TBI.MFCU@tn.gov; ProgramIntegrity.TennCare@tn.gov). Along with a notification, the CONTRACTOR shall take steps to triage and/or substantiate these tips and provide simultaneous and timely updates to TBI MFCU and the TennCare Office of Program Integrity when the concerns and/or allegations of any tips are authenticated.

7. **Section 2.20.2 shall be amended by adding a new Section 2.20.2.14 as follows and renumbering the remaining Sections accordingly, including any references thereto.**

2.20.2.14 If the CONTRACTOR subjects a provider (who is not otherwise listed as under investigation or litigation involving the State or Federal government) to pre-payment review or any review requiring the provider to submit documentation to support a claim prior to the CONTRACTOR considering it for payment, as a result of suspected fraud, waste, and/or abuse, the CONTRACTOR shall adhere to the following, within ninety (90) days of requiring such action:

2.20.2.14.1 Conduct a retrospective medical and coding review on the relevant claims; and

2.20.2.14.2 If fraud, waste or abuse is still suspected after conducting the retrospective review, submit to TennCare Program Integrity a suspected fraud referral, including all referral components as required by TennCare Program Integrity.

2.20.2.14.3 A retrospective review shall not be conducted for providers who are listed as under investigation or litigation involving the State or Federal government or other instances as deemed appropriate by TENNCARE.

8. **Section 2.20.3.6 shall be deleted and replaced as follows:**

2.20.3.6 The CONTRACTOR shall have provisions in its Compliance Plan regarding conducting monthly comparison of their provider files, including atypical providers, against the Social Security Master Death File, the Excluded Parties List System (EPLS) and the HHS-OIG List of Excluded Individuals/Entities (LEIE) and provide a report of the result of comparison to TENNCARE each month. The CONTRACTOR shall establish an electronic database to capture identifiable information on the owners, agents and managing employees listed on providers' Disclosure forms.

9. **Section 2.30.3 shall be deleted and replaced as follows:**

A.2.30.3 **Community Outreach Plan Reports**

2.30.3.1 The CONTRACTOR shall submit an Annual Community Outreach Plan on December 1st of each year and must be written in accordance with guidance provided in Section A.2.7.4.2.1.

2.30.3.2 The CONTRACTOR shall submit a Quarterly Outreach Update thirty (30) days following the end of each quarter.

2.30.3.3 The CONTRACTOR shall submit a Year-End Outreach Update forty-five (45) days following the end of the calendar year.



Amendment 39 (cont.)

10. **Section 2.30.4.4 shall be deleted and replaced as follows:**

2.30.4.4 The CONTRACTOR shall submit a *TennCare Kids and Quarterly Outreach Activities Report* which shall be in a format designated by TENNCARE and shall include a listing of related and non-related TennCare Kids events.

11. **Section 2.30.12 shall be amended by adding a new Section 2.30.12.10 and 2.30.12.11 as follows:**

2.30.12.10 The CONTRACTOR shall submit a quarterly Home Health Critical Incident Report in accordance with Section A.2.15.7.3 that provides information, by month regarding specified measures, which shall include but not be limited to the following:

2.30.12.10.1 The number of Critical Incidents, overall and by:

2.30.12.10.1.1 Date of Critical Incident;

2.30.12.10.1.2 Type of Critical Incident;

2.30.12.10.1.3 Location;

2.30.12.10.1.4 Provider name; and

2.30.12.10.1.5 Action Taken by Facility/Provider.

2.30.12.11 The CONTRACTOR shall report to TENNCARE any death and any incident that could significantly impact the health or safety of a member (e.g., physical or sexual abuse) within twenty-four (24) hours of detection or notification.

2.30.12.11.1 For HHA Critical Incidents the CONTRACTOR shall submit an updated report, including results of investigation and next steps to TENNCARE within thirty (30) calendar days of notification of the incident.

12. **Section 2.30.13.1.2 and 2.30.13.1.3 shall be amended by deleting the last sentence so the amended Sections read as follows:**

2.30.13.1.2 The CONTRACTOR shall submit a quarterly 24/7 Nurse Triage Line Report that lists the total calls received by the 24/7 nurse triage line, including the number of calls from CHOICES members, including the ultimate disposition of the call (e.g. education only, no referral for care; referred to primary care provider for care, referred to emergency department for care, transfers to a care coordinator (for CHOICES members)).

2.30.13.1.3 The CONTRACTOR shall submit a quarterly ED Assistance Tracking Report that provides the total number of calls received pertaining to patients in EDs needing assistance in accessing care in an alternative setting. Such report shall include the date and time of the call, identifying information for the member, the name and location of the hospital, the ultimate response to the call (e.g. appointment made with PCP) and the elapsed time from ED visit until appointment in alternative setting.



13. Section 2.30.22 shall be deleted and replaced as follows:

2.30.22 Non-Discrimination Compliance Reports

- 2.30.22.1 In June of every year this Contract is in effect, HCFA shall provide the CONTRACTOR with a Nondiscrimination Compliance Questionnaire. The CONTRACTOR shall answer the questions contained in the Compliance Questionnaire and submit the completed Questionnaire to HCFA within sixty (60) calendar days of receipt of the Compliance Questionnaire from HCFA with any requested documentation, which shall include, the CONTRACTOR's Assurance of Nondiscrimination. The signature date of the CONTRACTOR's Nondiscrimination Compliance Questionnaire shall be the same as the signature date of the CONTRACTOR's Assurance of Nondiscrimination. The Nondiscrimination Compliance Questionnaire deliverables shall be in a format specified by HCFA.
- 2.30.22.1.1 As part of the requested documentation for the Nondiscrimination Compliance Questionnaire, the CONTRACTOR shall submit copies of its nondiscrimination policies and procedures that demonstrate nondiscrimination in the provision of its services, programs, or activities provided under this Contract. These policies shall include topics, such as, working to reduce and end health disparities, the provision of language and communication assistance services for LEP individuals and individuals that require effective communication assistance in alternative formats (auxiliary aids or services), and providing assistance to individuals with disabilities. Any nondiscrimination policies and procedures that are specific to HCFA program members shall be prior approved in writing by HCFA.
- 2.30.22.2 As a part of the requested documentation for the Nondiscrimination Compliance Questionnaire the CONTRACTOR shall include reports that capture data for all language and communication assistance services used and provided by the CONTRACTOR under this Contract. One report shall contain the names of the CONTRACTOR's language and communication assistance service providers, the languages that interpretation and translation services are available in, the auxiliary aids or services that were provided and that are available, the hours the language and communication assistance services are available, and the numbers individuals call to access language and communication assistance services. A separate report that captures a listing of language and communication assistance services that were requested by members (i.e. Arabic; Braille) and the methods used to provide the language and alternative communication service to the members (i.e. interpretation; translation). In addition, the report shall contain a listing of the number of LEP members that are enrolled in the MCO broken down by county and the languages that are spoken by these members. Upon request the CONTRACTOR shall provide a more detailed report that contains the requestor's name and identification number, the requested service, the date of the request, the date the service was provided, and the name of the service provider.
- 2.30.22.3 The CONTRACTOR shall submit a quarterly *Non-discrimination Compliance Report* which shall include the following:
- 2.30.22.3.1 A summary listing that captures the total number of the CONTRACTOR's new hires that have completed civil rights/nondiscrimination training and cultural competency training and the dates the trainings were completed for that quarter; and



Amendment 39 (cont.)

- 2.30.22.3.1.1 A listing of the total number of the CONTRACTOR's employees that have completed annual civil rights training and cultural competency training and the dates completed for that quarter, if annual training was provided during that quarter.
- 2.30.22.3.2 An update of all written discrimination complaints filed by individuals, such as, employees, members, providers and subcontractors in which the discrimination allegation is related to the provision of and/or access to TennCare covered services provided by the CONTRACTOR, which the CONTRACTOR is assisting TENNCARE with resolving. This update shall include, at a minimum: identity of the complainant, complainant's relationship to the CONTRACTOR, circumstances of the complaint, type of covered service related to the complaint, date complaint filed, the CONTRACTOR's resolution, date of resolution, and the name of the CONTRACTOR staff person responsible for adjudication of the complaint. For each complaint reported as resolved the CONTRACTOR shall submit a copy of the complainant's letter of resolution.
- 2.30.22.3.2.1 The CONTRACTOR shall also provide a listing of all discrimination claims that are reported to the CONTRACTOR that are claimed to be related to the provision of and/or access to TennCare covered services provided by the CONTRACTOR. This listing shall include, at a minimum: identity of the person making the report, the person's relationship to the CONTRACTOR, circumstances of the report, type of covered service related to the report, date of the report, the CONTRACTOR's resolution, and date of resolution. When such reports are made, the CONTRACTOR shall offer to provide discrimination complaint forms to the individual making the report.
- 2.30.22.3.3 The language and communication assistance report shall capture a summary listing of the language and alternative communication services that were requested by the members (i.e. Arabic; Braille) and the method used to provide the language and alternative communication service to the members (i.e. interpretation; translation). In addition, the report shall contain a listing of the number of LEP members that are enrolled in the MCO broken down by county and the languages that are spoken by these members. Upon request the CONTRACTOR shall provide a more detailed report that contains the member's identification number, the requested service, the date of the request, the date the service was provided and the name of the service provider.
- 2.30.22.4 By September 15 of each year, the CONTRACTOR shall begin distributing adult and child member health disparities surveys. These surveys shall be conducted over a period of 10 weeks. The CONTRACTOR shall use a mixed mode (email, telephone, and mail) survey method or other survey methods approved by TENNCARE.
- 2.30.22.4.1 TENNCARE shall provide the CONTRACTOR with survey questions that capture the following five (5) measurements: access to care; provider communication; provider rating; MCO communication; and MCO rating. The results of these surveys shall be reported at statewide and Grand Region levels and shall be segmented by the members' race and ethnicity, language, disability, sex, sexual orientation (only for adults) statuses. The survey measurements may also be used to report members' experiences based on members' health needs/Chronic Conditions.
- 2.30.22.4.2 On December 15 of each year, the CONTRACTOR shall submit the survey results in an annual Report on Health Disparities that includes recommendations for improvements based on the survey results. The CONTRACTOR shall collaborate with TENNCARE and other



Amendment 39 (cont.)

entities designated by TENNCARE to develop and implement projects to reduce health disparities.

14. **Section 3.2.4 shall be deleted and replaced as follows:**

3.2.4 Provide care coordination and case management consistent with state and federal Medicaid regulations.

15. **Level A.4 of Section 5.20.2.2.7 shall be amended by adding additional language as follows:**

A.4	Failure to comply with obligations and time frames in the delivery of TennCare Kids screens and related services	The actual amount paid by DCS and/or TENNCARE for necessary services or \$1,000, whichever is greater AND \$10,000 per Region for Screening Rate below 85% as determined from CMS 416 MCO Report \$25,000 per Region for Screening Rate below 80% as determined from CMS 416 MCO Report \$50,000 per Region for Screening Rate below 75% as determined from CMS 416 MCO Report
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Amendment 39 (cont.)

All of the provisions of the original Contract not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective July 1, 2016.

The State is not bound by this Amendment until it is signed by the contract parties and approved by appropriate officials in accordance with applicable Tennessee laws and regulations (depending upon the specifics of this Contract, said officials may include, but are not limited to, the Commissioner of Finance and Administration, the Commissioner of Human Resources, and the Comptroller of the Treasury).

The CONTRACTOR, by signature of this Amendment, hereby affirms that this Amendment has not been altered and therefore represents the identical document that was sent to the CONTRACTOR by TENNCARE.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

VOLUNTEER STATE HEALTH PLAN, INC.

BY: Larry B. Martin /ed
Larry B. Martin
Commissioner

BY: Amber Cambron
Amber Cambron
President & CEO VSHP

DATE: 6/10/2016

DATE: 6/9/16



CONTRACT SUMMARY SHEET

66-00026	Edison #	29635	Contract Number:	FA-02-14632-38
State Agency: Department of Finance and Administration			Division:	Bureau of TennCare
Contractor			Contract Identification Number	
VSHP (TennCare Select)			<input type="checkbox"/> V- <input type="checkbox"/> C-	Edison Vendor #0000071694

Service Description

Managed Care Organization / Medically Necessary Health Care Services to the TennCare/Medicaid Population

Contract Begin Date				Contract End Date		
7/1/2001				12/31/2016		
Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66		134	11	<input type="checkbox"/> STARS		
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)	
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$ 18,599,868.48	
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$ 33,079,942.80	
2004	\$ 25,125,990.72	\$ 38,364,165.90			\$ 63,490,156.62	
2005	\$ 58,007,447.00	\$ 58,007,447.00			\$ 116,014,894.00	
2006	\$ 87,748,111.00	\$ 87,748,111.00			\$ 175,496,222.00	
2007	\$ 87,748,111.00	\$ 87,748,111.00			\$ 175,496,222.00	
2008	\$ 72,610,000.00	\$ 127,390,000.00			\$ 200,000,000.00	
2009	\$ 72,610,000.00	\$ 127,390,000.00			\$ 200,000,000.00	
2010	\$ 100,882,479.00	\$ 304,024,121.00			\$ 404,906,600.00	
2011	\$ 131,085,619.00	\$ 312,820,981.00			\$ 443,906,600.00	
2012	\$ 149,893,942.00	\$ 294,012,658.00			\$ 443,906,600.00	
2013	\$ 150,102,578.00	\$ 293,804,022.00			\$ 443,906,600.00	
2014	\$ 153,147,777.00	\$ 290,758,823.00			\$ 443,906,600.00	
2015	\$ 155,078,771.00	\$ 288,827,829.00			\$ 443,906,600.00	
2016	\$ 155,211,942.69	\$ 288,694,657.31			\$ 443,906,600.00	
2017	\$ 77,605,971.34	\$ 144,347,328.66			\$ 221,953,300.00	
Total:	\$ 1,499,399,800.38	\$ 2,773,077,005.52			\$ 4,272,476,805.90	

CFDA#	93.778 Title XIX Dept. of Health & Human Svcs.	Check the box ONLY if the answer is YES:	
State Fiscal Contract		Is the Contractor a SUBRECIPIENT? (per OMB A-133)	
Name:	Casey Dungan	Is the Contractor a Vendor? (per OMB A-133)	
Address:	310 Great Circle Road Nashville, TN	Is the Fiscal Year Funding STRICTLY LIMITED?	
Phone:	(615)507-6482	Is the Contractor on STARS?	
Procuring Agency Budget Officer Approval Signature		Is the Contractor's FORM W-9 ATTACHED?	
Casey Dungan		Is the Contractor's Form W-9 Filed with Accounts?	

COMPLETE FOR ALL AMENDMENTS (only)			Funding Certification
	Base Contract & Prior Amendments	This Amendment ONLY	Funding Certification (certification, required by T.C.A., § 9-4-5113, that there is a balance in the appropriation from which the obligated expenditure is required to be paid that is not otherwise encumbered to pay obligations previously incurred)
CONTRACT END DATE:	12/31/2016		
FY: 2002	\$ 18,599,868.48		
FY: 2003	\$ 33,079,942.80		
FY: 2004	\$ 63,490,156.62		
FY: 2005	\$ 116,014,894.00		
FY: 2006	\$ 175,496,222.00		
FY: 2007	\$ 175,496,222.00		
FY: 2008	\$ 200,000,000.00		
FY: 2009	\$ 200,000,000.00		
FY: 2010	\$ 404,906,600.00		
FY: 2011	\$ 443,906,600.00		
FY: 2012	\$ 443,906,600.00		
FY: 2013	\$ 443,906,600.00		
FY: 2014	\$ 443,906,600.00		
FY: 2015	\$ 443,906,600.00		
FY: 2016	\$ 443,906,600.00		
FY: 2017	\$ 221,953,300.00		
Total:	\$ 4,272,476,805.90	\$ -	



**AMENDMENT NUMBER 38
AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.**

CONTRACT NUMBER: FA-02-14632-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as specified below.

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. **The contract shall be amended by deleting the word “TENnderCare” throughout and replacing it with “TennCare Kids”.**
2. **Section 1 shall be amended by adding the definition of Ethical and Religious Directives as follows:**

Ethical and Religious Directives (often called the ERDs) means a document that offers moral guidance on various aspects of health care delivery and is based on a religious organization’s theological and moral teachings.

3. **“Inpatient, Residential & Outpatient Substance Abuse Benefit¹” in Section 2.6.1.4 shall be deleted and replaced as follows:**

SERVICE	BENEFIT LIMIT
Inpatient, Residential & Outpatient Substance Abuse Benefits¹	Medicaid/Standard Eligible, Age 21 and older: Covered as medically necessary . Medicaid/Standard Eligible, Under age 21: Covered as medically necessary.

¹When medically appropriate, services in a licensed substance abuse residential treatment facility may be substituted for inpatient substance abuse services. Methadone clinic services are not covered for adults.

4. **Section 2.7.4.2.2 through 2.7.4.2.4 shall be deleted and replaced as follows. All Section references shall be updated accordingly.**

2.7.4.2.2 By December 1, 2015, the CONTRACTOR shall submit an Annual Outreach Plan to TENNCARE with subsequent annual plans due on January 15th of each year.

2.7.4.2.2.1 Each plan must include:



Amendment 38 (cont.)

- 2.7.4.2.2.1.1 Methodology for developing the plan to include data assessments conducted, policy and procedure reviews, and any research that may have been conducted.
 - 2.7.4.2.2.1.2 Outreach efforts must include both written and oral communications and must address both rural and urban areas of the state and efforts to reach minorities and other underserved populations.
 - 2.7.4.2.2.1.3 Outreach efforts to teens.
 - 2.7.4.2.2.1.4 Interim evaluation criteria.
 - 2.7.4.2.2.1.5 Annual evaluation criteria.
 - 2.7.4.2.2.2 Each plan must be resubmitted quarterly with updates on progress included.
 - 2.7.4.2.3 A list of community events and other health education events, both related and unrelated to TennCare Kids shall be included in the quarterly TennCare Kids Report (See Section 2.30.4.4) in a format specified by TENNCARE. The list must include designation of either TennCare Kids or Other as well as the county in which the event was held.
5. **Section 2.7.6.2.4 through 2.7.6.2.10.2 shall be deleted and replaced as follows. All Section references shall be updated accordingly.**
- 2.7.6.2.4 As part of its TennCare Kids policies and procedures, the CONTRACTOR shall have a written process for following up with members who do not get their screenings timely. This process for follow up shall include provisions for documenting all outreach attempts and maintaining records of efforts made to reach out to members who have missed screening appointments or who have failed to receive regular check-ups.
 - 2.7.6.2.5 The CONTRACTOR shall have a process for determining if a member who is eligible for TennCare Kids has used no services within a year. Two (2) reasonable attempts to re-notify such members about TennCare Kids must be made and shall be in different formats.
 - 2.7.6.2.6 The CONTRACTOR shall make available to members and families accurate lists of names and phone numbers of contract providers who are currently accepting TennCare members as described in Section A.2.17.8 of this Contract.
 - 2.7.6.2.7 The CONTRACTOR shall target specific informing activities to pregnant women and families with newborns. Provided that the CONTRACTOR is aware of the pregnancy, the CONTRACTOR shall inform all pregnant women prior to the estimated delivery date about the availability of TennCare Kids services for their children. The CONTRACTOR shall offer TennCare Kids services for the child when it is born.
 - 2.7.6.2.8 The CONTRACTOR shall provide member education and outreach in community settings. Outreach events shall be conducted each the Grand Region, including rural and urban areas, covered by this Contract.



Amendment 38 (cont.)

6. **Section 2.8.2.1.1 shall be deleted and replaced as follows:**

2.8.2.1.1 The CONTRACTOR shall make reasonable attempts to assess member's health risk utilizing the appropriate common mini-health appraisal approved by the Bureau and Population Health staff or a comprehensive health risk assessment. The information collected from these health appraisals will be used to align individual members with appropriate intervention approaches and maximize the impact of the services provided. Members exempt from the mini-health appraisal are detailed in Section 2.8.3.1 of this Contract.

7. **Section 2.8.3.1 shall be deleted and replaced as follows:**

2.8.3.1 At time of enrollment and annually thereafter, the CONTRACTOR shall make a reasonable attempt to assess the member's health as detailed in Section 2.8.2.1.1 of this Contract. The comprehensive health risk assessment required by Level 2 Population Health programs, CHOICES, Dual Special Needs Program (D-SNP), Select Community, and Department of Children's Services (DCS) can be used in lieu of the mini-health appraisal required by the contract. A completed approved mini-health appraisal or a comprehensive health risk assessment done in the prior twelve (12) months may be shared among TennCare MCOs and used to meet the annual requirement.

8. **Item 8 of Amendment 37 sought to amend Section 2.9.6.6.2.5.4 but inadvertently contained a typo by stating the Section number incorrectly as 2.9.6.6.2.6.4. This correct Section reference is 2.9.6.6.2.5.4.**

9. **Item 9 of Amendment 37 sought to amend Section 2.9.6.6.2.6 but inadvertently contained a typo by stating the Section number incorrectly as 2.9.6.6.2.7. This correct Section reference is 2.9.6.6.2.6.**

10. **Section 2.9.14 shall be amended by adding a new Section 2.9.14.10 as follows:**

2.9.14.10 For dual eligible members aligned in the CONTRACTOR's MCO for Medicaid benefits and the CONTRACTOR's D-SNP for Medicare benefits, the CONTRACTOR shall manage all Medicaid and Medicare benefits locally (i.e., in Tennessee) and in an integrated manner.

2.9.14.10.1 There shall be a single point of coordination for aligned full benefit dual eligible members across the member's Medicaid and Medicare benefits.

2.9.14.10.2 The Care Coordinator of any dual eligible member enrolled in CHOICES and in the CONTRACTOR's DSNP shall be responsible for coordinating the full range of Medicaid, including LTSS, and Medicare benefits, have access to all of the information needed to do so, and the CONTRACTOR's systems and business process shall support an integrated approach to care coordination and service delivery.

2.9.14.10.3 The CONTRACTOR's systems shall be configured and the CONTRACTOR's operations shall be structured to facilitate the coordination of Medicaid and Medicare services in an integrated way. This includes the availability of consistent data for care coordination purposes across both the Medicaid and D-SNP plans. This is particularly crucial for CHOICES members and members identified for CHOICES screening.



Amendment 38 (cont.)

11. **Section 2.12.9 shall be amended by adding a new Section 2.12.9.66.5 as follows:**

2.12.9.66.5 For Provider Agreement that include Ethical and Religious Directives provisions, include the following requirements:

2.12.9.66.5.1 The Provider shall provide a list of the services it does not deliver due to the Ethical and Religious Directives to the CONTRACTOR. The CONTRACTOR shall furnish this list to TENNCARE, notating those services that are TennCare covered services. This list shall be used by the CONTRACTOR and TENNCARE to provide information to TennCare members about where and how the members can obtain the services that are not being delivered by the Provider due to Ethical and Religious Directives.

2.12.9.66.5.2 At the time of service, the Provider shall inform TennCare members of the health care options that are available to the TennCare members, but are not being provided by the Provider due to the Ethical and Religious Directives, but the Provider is not required to make specific recommendations or referrals. In addition, the Provider shall inform TennCare members that the member's MCO has additional information on providers and procedures that are covered by TENNCARE.

12. **Section 2.16.2 shall be deleted and the remaining Section 2.16 shall be renumbered accordingly, including any references thereto.**

13. **Section 2.17.5 shall be deleted and replaced as follows:**

2.17.5 Quarterly Member Newsletter

2.17.5.1 General Newsletter

The CONTRACTOR shall, at a minimum, distribute on a quarterly basis a newsletter to all members which is intended to educate the enrollee to the managed care system, proper utilization of services, etc., and encourage utilization of preventive care services.

2.17.5.1.1 In addition to the requirements described in Section 2.17.5.3, the CONTRACTOR shall include the following in each General Newsletter:

2.17.5.1.1.1 At least one specific article targeted to CHOICES members; and

2.17.5.1.1.2 Notification regarding the CHOICES program, including a brief description and whom to contact for additional information.

2.17.5.2 Teen Newsletter

The CONTRACTOR shall, at a minimum, distribute on a quarterly basis a newsletter to all enrollees between the ages of 15 and 20 which is intended to educate the enrollee to the managed care system, proper utilization of services and provide TennCare Kids information with an emphasis on the encouragement to utilize TennCare Kids services, including screenings and other preventive care services.



Amendment 38 (cont.)

- 2.17.5.2.1 In addition to the requirements described in Section, 2.17.5.3, the Teen Newsletter shall be a product of the TennCare Kids MCC Collaborative. The MCOs will agree on five required topics to include in each newsletter. MCOs may include additional articles at their discretion; no deviation from the five agreed upon articles will be allowed unless approved in writing by TENNCARE.
- 2.17.5.2.2 Distribution of the teen newsletter may be accomplished by a format chosen by the CONTRACTOR such as social media. The format should be chosen as an effort to reach the teen population most effectively.
- 2.17.5.3 The CONTRACTOR shall include the following information in each newsletter:
 - 2.17.5.3.1 Specific articles or other specific information as described when requested by TENNCARE. Such requests by TENNCARE shall be limited to two hundred (200) words and shall be reasonable including sufficient notification of information to be included;
 - 2.17.5.3.2 The procedure on how to obtain information in alternative communication formats, such as auxiliary aids or services and how to access language assistance services (i.e., interpretation and translation services) as well as a statement that interpretation and translation services and auxiliary aids or services are free;
 - 2.17.5.3.3 A notice of the right to file a discrimination complaint, as provided for by applicable federal and state civil rights laws, including, but not limited to Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, Title IX of the Education amendments of 1972, Section 504 of the Rehabilitation Act of 1973, and Titles II and III of the Americans with Disabilities Act of 1990 that includes a phone number for assistance and a website link to the complaint form. The notice shall be considered a Vital Document and shall be available at a minimum in the English and Spanish languages;
 - 2.17.5.3.4 TennCare Kids information, including but not limited to, encouragement to obtain screenings and other preventive care services;
 - 2.17.5.3.5 Information about appropriate prescription drug usage;
 - 2.17.5.3.6 TENNCARE and MCO member services toll-free telephone numbers, including the TENNCARE hotline, the CONTRACTOR's member services information line, and the CONTRACTOR's 24/7 nurse triage/advice line as well as the service/information that may be obtained from each line; and
 - 2.17.5.3.7 The following statement: "To report fraud or abuse to the Office of Inspector General (OIG) you can call toll-free 1-800-433-3982 or go online to <http://tn.gov/tenncare> and click on 'Stop TennCare Fraud'. To report provider fraud or patient abuse to the Medicaid Fraud Control Unit (MFCU), call toll-free 1-800-433-5454."
- 2.17.5.4 The quarterly member newsletters shall be disseminated within thirty (30) calendar days of the start of each calendar year quarter. In order to satisfy the requirement to distribute the quarterly general newsletter to all members, it shall be acceptable to mail one (1) quarterly newsletter to each address associated with the member's TennCare case number. The teen newsletter may be distributed in alternative formats chosen by the CONTRACTOR. In addition to the prior authorization requirement regarding dissemination of materials to members, the CONTRACTOR shall also submit to TENNCARE, the following proof of distribution:



Amendment 38 (cont.)

- 2.17.5.4.1 For the general newsletter, submit a final copy and documentation from the MCO's mail room or outside vendor indicating the quantity and date mailed as proof of compliance by the 30th of the month following each quarter.
- 2.17.5.4.2 For the teen newsletter, submit a final copy, describe the method/media the CONTRACTOR used to disseminate the newsletter and documentation from the MCO's responsible staff/vendor indicating the quantity and date disseminated as proof of compliance by the 30th of the month following each quarter.
14. **Section 2.18.3 shall be amended as follows:**
- 2.18.3 **Cultural Competency**
- As required by 42 CFR 438.206, the CONTRACTOR and its Providers and Subcontractors that are providing services pursuant to this Contract shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with Limited English Proficiency, disabilities and diverse cultural and ethnic backgrounds regardless of an enrollee's gender, sexual orientation, or gender identity. This includes the CONTRACTOR emphasizing the importance of network providers to have the capabilities to ensure physical access, accommodations, and accessible equipment for the furnishing of services to enrollees with physical or mental disabilities.
15. **Section 2.20.2.3 shall be amended by deleting and replacing the website link as follows:**
- 2.20.2.3 The CONTRACTOR shall notify TBI MFCU and TennCare Office of Program Integrity simultaneously and in a timely manner regarding all internal (such as identified patterns of data mining outliers, audit concerns, critical incidences) and external (such as hotline calls) tips with potential implications to TennCare providers' billing anomalies and/or to safety of TennCare enrollees (<http://tn.gov/finance/article/fa-oig-report-fraud>; ProgramIntegrity.TennCare@tn.gov). Along with a notification, the CONTRACTOR shall take steps to triage and/or substantiate these tips and provide simultaneous and timely updates to TBI MFCU and the TennCare Office of Program Integrity when the concerns and/or allegations of any tips are authenticated.
16. **Section 2.20.3.4 shall be amended by deleting the website link: (<http://www.tn.gov/tenncare/forms/fa10-001.pdf>).**
17. **Section 2.26.12.2 shall be deleted and replaced as follows:**
- 2.26.12.2 As required in Section 2.30.20 of this Contract, where the CONTRACTOR has subcontracted claims processing for TennCare claims, the CONTRACTOR shall provide to TENNCARE a Type II SOC1 examination based on the Statement on Standards for Attestation Engagements (SSAE) No. 16.
18. **Section 2.27.10.7 shall be amended by deleting and replacing the website link as follows:**
- 2.27.10.7 Loss or Suspected Loss of Data – If an employee of the CONTRACTOR becomes aware of suspected or actual loss of PHI/PII, the appropriate designee of the CONTRACTOR must



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immediately contact TENNCARE upon becoming aware to report the actual or suspected loss. The CONTRACTOR will use the Loss Worksheet located at http://tn.gov/assets/entities/tenncare/attachments/phi_piiworksheet.pdf to quickly gather and organize information about the incident. The CONTRACTOR must provide TENNCARE with timely updates as any additional information about the loss of PHI/PII becomes available.

19. **Section 2.28 shall be amended by deleting and replacing Sections 2.28.2.1, 2.28.5, and 2.28.7 and adding new Sections 2.28.9 and 2.28.10 as follows:**

- 2.28.2.1 The Contractor's Nondiscrimination Compliance Coordinator ("NCC") shall develop a CONTRACTOR nondiscrimination compliance training plan within thirty (30) days of the implementation of this Contract, to be approved by the Bureau of TennCare. This person shall be responsible for the provision of instruction regarding the plan to all CONTRACTOR staff within sixty (60) days of the implementation of this Contract. This person shall be responsible for the provision of instruction regarding the plan to providers and direct service subcontractors within ninety (90) days of the implementation of this Contract. The CONTRACTOR shall be able to show documented proof of such instruction.
- 2.28.2.1.1 On an annual basis, the NCC shall be responsible for making nondiscrimination training available to all CONTRACTOR staff and to its providers and subcontractors that are considered to be recipients of federal financial assistance under this Contract. The CONTRACTOR shall be able to show documented proof that the training was made available to the CONTRACTOR's staff and to its providers and subcontractors that are considered to be recipients of federal financial assistance under this Contract.
- 2.28.5 The CONTRACTOR shall keep such records as may be necessary in order to submit timely, complete and accurate compliance reports that may be requested by the U.S. Department of Health and Human Services ("HHS"), HCFA, and the Tennessee Human Rights Commission ("THRC") or their designees. If requested, the information shall be provided in a format and timeframe specified by HHS, HCFA, or THRC. The requested information may be necessary to enable HHS, HCFA, or THRC to ascertain whether the CONTRACTOR is complying with the applicable civil rights laws. For example, the CONTRACTOR should have available data showing the manner in which services are or will be provided by the program in question, and related data necessary for determining whether any persons are or will be denied such services on the basis of prohibited discrimination. Further examples of data that could be requested can be found at 45 C.F.R. § 80.6 and 28 C.F.R. § 42.406.
- 2.28.5.1 The CONTRACTOR shall permit access as set forth in the applicable civil rights laws, such as, 45 C.F.R. § 80.6 to HHS, HCFA, and THRC or their designees during normal business hours to such of its books, records, accounts, and other sources of information, and its facilities as may be pertinent to ascertain whether the CONTRACTOR is complying with the applicable civil rights laws.
- 2.28.5.2 The CONTRACTOR shall make available to beneficiaries and participants in HCFA's programs and other interested persons information regarding the provisions of the applicable civil rights laws as set forth in the implementing regulations, including 45 C.F.R. § 80.6 and 45 C.F.R. § 84.8. For example, a notification shall state, where appropriate, that the CONTRACTOR does not discriminate in admission or access to, or treatment or employment



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in, its programs or activities. The notification shall also include an identification of the responsible employee designated for its nondiscrimination compliance. This notice shall be considered a vital document and shall be available at a minimum in the English and Spanish languages.

- 2.28.7 The CONTRACTOR shall use and have available to TennCare enrollees, TennCare's Discrimination complaint form located on TennCare's website under the nondiscrimination link at <http://tn.gov/tenncare/topic/non-discrimination-compliance>. The discrimination complaint form shall be provided to TennCare enrollees upon request and in the member handbook. This complaint form shall be considered a Vital Document and shall be available at a minimum in the English and Spanish languages. When requests for assistance to file a discrimination complaint are made by enrollees, the CONTRACTOR shall assist the enrollees with submitting complaints to TENNCARE. In addition, the CONTRACTOR shall inform its employees, providers, and subcontractors how to assist TENNCARE enrollees with obtaining discrimination complaint forms and assistance from the CONTRACTOR with submitting the forms to TENNCARE and the CONTRACTOR.
- 2.28.9 Should the CONTRACTOR not cover a TennCare covered service because of moral/ethical or religious reasons, the CONTRACTOR shall provide a list of these services to TENNCARE. This list shall be used by TENNCARE to provide information to TennCare members about where and how the members can obtain the services that are not being delivered due to Ethical and Religious Directives.
- 2.28.9.1 Should the CONTRACTOR contract with providers and/or subcontractors to deliver services to TennCare members pursuant to the CONTRACTOR'S obligations under this agreement and the providers or subcontractors cannot provide a TennCare covered service because of moral/ethical or religious reasons, the CONTRACTOR shall provide a list of these services to TENNCARE. This list shall be used by the CONTRACTOR and TENNCARE to provide information to TennCare members about where and how the members can obtain the services that are not being delivered due to Ethical and Religious Directives.
- 2.28.10 Electronic and Information Technology Accessibility Requirements. To the extent that the CONTRACTOR is using electronic and information technology to fulfill its obligations under this Contract, the CONTRACTOR agrees to comply with the electronic and information technology accessibility requirements under the federal civil rights laws including Section 504 and Section 508 of the Rehabilitation Act of 1973 ("Section 508") and the Americans with Disabilities Act. To comply with the accessibility requirements for Web content and non-Web electronic documents and software, the CONTRACTOR shall use W3C's Web Content Accessibility Guidelines ("WCAG") 2.0 AA (For the W3C's guidelines see: <http://www.w3.org/TR/WCAG20/>) (Two core linked resources are Understanding WCAG 2.0 <http://www.w3.org/TR/UNDERSTANDING-WCAG20/> and Techniques for WCAG 2.0 <http://www.w3.org/TR/WCAG20-TECHS/>).
- 2.28.10.1 Should the CONTRACTOR have a designated staff member responsible for CONTRACTOR's electronic and information technology accessibility compliance, the name and contact information for this individual shall be provided to HCFA within ten (10) days of the implementation of this Contract and within ten (10) days of this position being reassigned to another staff member.
- 2.28.10.2 CONTRACTOR agrees to perform regularly scheduled (i.e., automatic) scans and manual testing for WCAG 2.0 AA compliance for all user content and applications in order to meet



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the standards for compliance. The CONTRACTOR must ensure that any system additions, updates, changes or modifications comply with WCAG 2.0 AA. Commercial Off-the-shelf ("COTS") products may be used to verify aspects of WCAG 2.0 AA compliance.

2.28.10.3 Additionally, the CONTRACTOR agrees to comply with Title VI of the Civil Rights Act of 1964. In order to achieve Title VI compliance the CONTRACTOR should add a system function that allows users to translate the content into a language other than English. This requirement may be satisfied by the provision of a link to Google translate or other machine translate tool.

2.28.10.4 Should the system or a component of the system fail to comply with the accessibility standards, the CONTRACTOR shall develop and submit to HCFA for approval a noncompliance report that identifies the areas of noncompliance, a plan to bring the system or component into compliance, an alternative/work around that provides users with the equivalent access to the content, and a timeframe for achieving that compliance. HCFA shall review the noncompliance report to determine whether or not it is acceptable and should be implemented. Once the noncompliance report is approved by HCFA the CONTRACTOR may implement the compliance plan. HCFA, in its sole discretion, shall determine when a satisfactory compliance plan resolution has been reached and shall notify the CONTRACTOR of the approved resolution. If CONTRACTOR is unable to obtain content that conforms to WCAG 2.0 AA, it shall demonstrate through its reporting to HCFA that obtaining or providing accessible content would fundamentally alter the nature of its goods and services or would result in an undue burden.

20. **Section 2.29.1.3.9 shall be amended as follows:**

2.29.1.3.9 A staff person to serve as the CONTRACTOR's Non-discrimination Compliance Coordinator. This person shall be responsible for the CONTRACTOR's compliance with applicable federal and state civil rights laws, regulations, rules and policies, including but not limited to, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Titles II and III of the Americans with Disabilities Act of 1990, and the Age Discrimination Act of 1975. The CONTRACTOR shall report to TENNCARE in writing, to its Office of Civil Rights Compliance within ten (10) calendar days of the commencement of any period of time that the CONTRACTOR does not have a designated staff person for non-discrimination compliance. The CONTRACTOR shall report to TENNCARE at such time that the function is redirected as required in Section 2.29.1.2;

21. **Section 2.30.3 shall be deleted and replaced as follows:**

2.30.3 Community Outreach

The CONTRACTOR shall submit an initial Annual Community Outreach Plan on December 1, 2015 with subsequent annual plans beginning January 15, 2017. These plans shall then be due on January 15th of each year and must be written in accordance with guidance provided in Section 2.7.4.2.2.

22. **Section 2.30.5.3 shall be deleted and replaced as follows:**

2.30.5.3 The CONTRACTOR shall submit annually, on July 1 after the close of the state calendar year, a *Population Health Annual Report* in the format described in the annual report template provided by TENNCARE. The report shall include active participation rates, as



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designated by NCQA, for programs with active interventions. Short term and intermediate outcome data reporting is required. Member satisfaction shall be reported based upon NCQA requirements along with functional status for members in the Chronic Care Management and Complex Case Management programs.

23. Section 2.30.7 shall be deleted and replaced in its entirety as follows and all Section references shall be renumbered accordingly:

2.30.7 Integrated Health Services Delivery Model Reports

- 2.30.7.1 The CONTRACTOR shall submit a quarterly *SelectCommunity Care Management and Member Reassessment Report*. The report shall include information on the CONTRACTOR's care management assignment, as well as current and cumulative performance on various measures, and shall include, but not be limited to, the following information:
 - 2.30.7.1.1 The member name, SSN, and DOB;
 - 2.30.7.1.2 Whether the member has complex unstable physical or behavioral health needs (see Section 3.A.14.3.), complex stable physical or behavioral health needs (see Section 3.A.14.4), or no complex physical or behavioral health needs;
 - 2.30.7.1.3 The assigned Nurse Care Manager (NCM) name, email address, and direct phone number;
 - 2.30.7.1.4 The NCM Supervisor name, email, and direct phone number;
 - 2.30.7.1.5 The average NCM-to-SelectCommunity member staffing ratio for 1) members of the former Arlington class and 2) other SelectCommunity members on the last business day of the month prior to the report submission (e.g., the report submitted in January 2012 will reflect the average staffing ratios as they appeared on December 31, 2011);
 - 2.30.7.1.6 The number of members of the former Arlington class and other SelectCommunity members assigned to each individual Nurse Care Manager on the last business day of the month prior to the report submission (e.g., the report submitted in January 2012 will reflect Nurse Care Manager assignments as they appeared on December 31, 2011);
 - 2.30.7.1.7 The number and percent of SelectCommunity members with complex unstable physical or behavioral health needs visited/ not visited in their residence face-to-face by their Nurse Care Manager at least monthly;
 - 2.30.7.1.8 The number and percent of SelectCommunity members with complex stable physical or behavioral health needs contacted/ not contacted by their Nurse Care Manager at least monthly either in person or by telephone, and visited/ not visited in their residence face-to-face by their Nurse Care Manager at least quarterly;
 - 2.30.7.1.9 The number and percent of SelectCommunity members with no complex physical or behavioral health needs contacted/ not contacted by their Nurse Care Manager at least quarterly either in person or by telephone, and visited/ not visited in their residence face-to-face by their Nurse Care Manager at least semi-annually;



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- 2.30.7.1.10 The number and percent of SelectCommunity members for whom the CONTRACTOR has/has not reassessed the member's physical and behavioral health needs at least once every 365 days ; and
- 2.30.7.1.11 The number and percent of SelectCommunity members for whom the CONTRACTOR has/has not reassessed the member's physical and behavior health needs within five (5) business days of becoming aware that the member's functional, physical, or behavioral status has changed significantly as defined by but not limited to section 3.A.8.1.1 thru 3.A.8.1.5.
- 2.30.7.2 The CONTRACTOR shall submit to TENNCARE a quarterly *SelectCommunity Delays in Service Report* as defined in Section 3.A.6.13.
- 2.30.7.3 The CONTRACTOR shall, using a tool and methodology approved by TENNCARE, conduct annual consumer satisfaction surveys of all SelectCommunity Members who are participating in the IHSD model, and shall provide such results to TENNCARE for review and dissemination.
24. **Section 2.30.16.2.2 shall be amended by deleting the following link: (<http://www.tn.gov/tenncare/forms/disclosureownership.pdf>).**
25. **Sections 2.30.20.1 and 2.30.20.2 through 2.30.20.2.2.4 shall be deleted and replaced as follows, including any references thereto.**
- 2.30.20.1 If the CONTRACTOR has subcontracted claims processing for TennCare claims, the CONTRACTOR shall provide to TENNCARE a Type II SOC1 examination based on the Statement on Standards for Attestation Engagements (SSAE) No. 16 for each non-affiliated organization processing claims that represent more than twenty percent (20%) of TennCare medical expenses of the CONTRACTOR. This report shall be performed by an independent auditor ("service auditor") and shall be due annually on May 1 for the preceding year operations or portion thereof.
- 2.30.20.2 In a Type II report, the auditor will express an opinion on whether the organization's description of controls presents the relevant aspects of the organization's actual controls in operation for the period specified in the report, typically one year. Also the report will determine whether the controls were suitably designed to achieve specified control objectives with sufficient effectiveness to provide reasonable, but not absolute assurance that the control objectives were achieved during the period specified.



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2.30.20.2.1 The service auditor will express an opinion on (1) whether the service organization's description of its controls presents fairly, in all material respects, the relevant aspects of the service organization's controls that had been placed in operation as of a specific date, and (2) whether the controls were suitably designed to achieve specified control objectives, and (3) whether the controls that were tested were operating with sufficient effectiveness to provide reasonable, but not absolute, assurance that the control objectives were achieved during the period specified.

26. Section 2.30.22 shall be deleted and replaced as follows:

2.30.22 Non-Discrimination Compliance Reports

2.30.22.1 In July of every year this Contract is in effect, HCFA shall provide the CONTRACTOR with a Nondiscrimination Compliance Questionnaire. The CONTRACTOR shall answer the questions contained in the Compliance Questionnaire and submit the completed Questionnaire to HCFA within thirty (30) calendar days of receipt of the Compliance Questionnaire from HCFA with any requested documentation, which shall include, the CONTRACTOR's Assurance of Nondiscrimination. The signature date of the CONTRACTOR's Nondiscrimination Compliance Questionnaire shall be the same as the signature date of the CONTRACTOR's Assurance of Nondiscrimination. The Nondiscrimination Compliance Questionnaire deliverables shall be in a format specified by HCFA.

2.30.22.1.1 As part of the requested documentation for the Nondiscrimination Compliance Questionnaire, the CONTRACTOR shall submit copies of its nondiscrimination policies and procedures that demonstrate nondiscrimination in the provision of its services, programs, or activities provided under this Contract. These policies shall include topics, such as, working to reduce and end health disparities, the provision of language and communication assistance services for LEP individuals and individuals that require effective communication assistance in alternative formats (auxiliary aids or services), and providing assistance to individuals with disabilities. Any nondiscrimination policies and procedures that are specific to HCFA program members shall be prior approved in writing by HCFA.

2.30.22.2 As a part of the requested documentation for the Nondiscrimination Compliance Questionnaire the CONTRACTOR shall include reports that capture data for all language and communication assistance services used and provided by the CONTRACTOR under this Contract. One report shall contain the names of the CONTRACTOR's language and communication assistance service providers, the languages that interpretation and translation services are available in, the auxiliary aids or services that were provided and that are available, the hours the language and communication assistance services are available, and the numbers individuals call to access language and communication assistance services. A separate report shall list all requests for language and communication assistance services, including the requestor's name and identification number, the requested service, the date of the request, the date the service was provided, and the name of the service provider.

2.30.22.3 The CONTRACTOR shall submit a quarterly *Non-discrimination Compliance Report* which shall include the following:



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- 2.30.22.3.1 A summary listing that captures the total number of the CONTRACTOR's new hires that have completed civil rights/nondiscrimination training and cultural competency training and the dates the trainings were completed for that quarter; and
 - 2.30.22.3.1.1 A listing of the total number of the CONTRACTOR's employees that have completed annual civil rights training and cultural competency training and the dates completed for that quarter, if annual training was provided during that quarter.
 - 2.30.22.3.2 An update of all written discrimination complaints filed by individuals, such as, employees, members, providers and subcontractors in which the discrimination allegation is related to the provision of and/or access to TennCare covered services provided by the CONTRACTOR, which the CONTRACTOR is assisting TENNCARE with resolving. This update shall include, at a minimum: identity of the complainant, complainant's relationship to the CONTRACTOR, circumstances of the complaint, type of covered service related to the complaint, date complaint filed, the CONTRACTOR's resolution, date of resolution, and the name of the CONTRACTOR staff person responsible for adjudication of the complaint. For each complaint reported as resolved the CONTRACTOR shall submit a copy of the complainant's letter of resolution.
 - 2.30.22.3.2.1 The CONTRACTOR shall also provide a listing of all discrimination claims that are reported to the CONTRACTOR that are claimed to be related to the provision of and/or access to TennCare covered services provided by the CONTRACTOR. This listing shall include, at a minimum: identity of the person making the report, the person's relationship to the CONTRACTOR, circumstances of the report, type of covered service related to the report, date of the report, the CONTRACTOR's resolution, and date of resolution. When such reports are made, the CONTRACTOR shall offer to provide discrimination complaint forms to the individual making the report.
 - 2.30.22.3.3 A listing of all member requests for language and communication assistance services. The report shall list the member, the member's identification number, the requested service, the date of the request, the date the service was provided and the name of the service provider.

27. **The Title Section 3A shall be amended as follows:**

3A. INTEGRATED HEALTH SERVICES DELIVERY MODEL FOR PERSONS WITH INTELLECTUAL DISABILITIES

28. **Section 3A.1.1 shall be amended as follows:**

3A.1.1 Notwithstanding any provision in this Contract to the contrary, the CONTRACTOR shall be responsible for the implementation of an Integrated Health Services Delivery Model (IHSD), known as "SelectCommunity," for persons with intellectual disabilities as set forth in this Section.

The model as defined herein includes the following:



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29. **Section 3.A.1.1.4 shall be amended as follows:**

3.A.1.1.4 Ongoing coordination with long-term care services the member receives, including Home and Community Based Services (HCBS) provided under a Section 1915(c) waiver program for persons with intellectual disabilities or Institutional services in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or Nursing Facility (NF), as applicable; and

30. **Section 3.A.1.3 shall be amended as follows:**

3.A.1.3 The cornerstone of the model is Nurse Care Management, which shall be provided by the CONTRACTOR as an administrative service, rather than a covered benefit. Each TennCare Select member within the target population shall have an assigned Nurse Care Manager. Nurse Care Managers shall develop an individualized, Integrated Plan of Health Care for each member, coordinate the full array of covered physical and behavioral health services eligible members need, and work closely with Independent Support Coordinators or Waiver Case Managers, as applicable and HCBS Waiver, ICF/IID and/or NF providers in implementing the Integrated Plan of Health Care which operates in conjunction with the member's Individual Support Plan. In addition to extensive professional nursing experience and expertise, Nurse Care Managers will receive training specific to the I/DD population, with particular focus on medical issues common in occurrence and nursing procedures frequently required for the I/DD population.

31. **Section 3.A.2.2 shall be amended as follows:**

3.A.2.2 The CONTRACTOR shall provide Nurse Care Management to all TennCare Select members in the former Arlington Class who are residing in public or private ICFs/IID, nursing homes or in other institutional or alternative home and community-based placements, which may include the person's (or family's) home, except that persons enrolled in the CHOICES program shall not participate in the Integrated Health Services Delivery Model. TENNCARE shall determine, at its discretion, whether members in the former Arlington class in nursing homes will be enrolled into CHOICES or into the Integrated Health Services Delivery Model. If the State elects to enroll members in the former Arlington class in nursing homes into the Integrated Health Services Delivery Model, such members who elect to opt out of the Integrated Health Services Delivery Model shall be required to enroll in CHOICES in order to receive nursing home services.

32. **Section 3.A.2.4 shall be deleted in its entirety and the remaining Section shall be renumbered accordingly, including any references thereto.**

33. **Section 3A.3.2.1 shall be amended as follows:**

3A.3.2.1 Such policies and procedures shall specify the role and authority of Nurse Care Managers in authorizing needed physical and behavioral health services. At the discretion of the CONTRACTOR, authorization of home health, private duty nursing, and direct therapy services (i.e., occupational, physical and speech therapy services) may be completed by the Nurse Care Manager or through the CONTRACTOR's established UM processes but shall be coordinated by the Nurse Care Manager to ensure timely access to needed care and coordination with HCBS Waiver benefits.



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34. **Section 3A.4.1 shall be amended as follows:**

- 3A.4.1 The CONTRACTOR shall, within five (5) business days after the date of SelectCommunity eligibility of each new member in the target population assign a specific Nurse Care Manager who shall have primary responsibility for performance of Nurse Care Management activities as specified in this Section, and who shall be the member's point of contact for coordination of physical and behavioral health services.
- 3.A.4.1.1 The CONTRACTOR shall establish a process for educating new members on the TennCare disenrollment process, including criteria for disenrollment.

35. **Section 3A.4.2 shall be amended as follows:**

- 3A.4.2 The CONTRACTOR shall, within ten (10) business days after the date of SelectCommunity eligibility of each new member in the target population into TennCare Select, provide written notice to the member including the name and contact information for his/her assigned Nurse Care Manager, and how to obtain assistance for urgent physical and behavioral health needs after hours.

36. **Section 3A.6.1. shall be amended as follows:**

- 3A.6.1 Upon completion of the assessment, the CONTRACTOR shall coordinate with a Care Management Support Team to develop an individualized, Integrated Plan of Health Care. Such plan shall be completed within thirty (30) calendar days of the date of SelectCommunity eligibility .

37. **Section 3A.6.6 shall be amended as follows:**

- 3A.6.6 For persons residing in Institutional Placements, the Integrated Plan of Health Care shall supplement the facility's plan of care (which is required pursuant to federal regulation), and shall focus on the provision of services covered by TennCare Select that are beyond the scope of the Institutional ICF/IID or NF benefit, including targeted strategies related to improving health, functional, or quality of life outcomes (e.g., related to Population Health or pharmacy management) or to increasing and/or maintaining health and/or functional status, as appropriate.

38. **Section 3A.6.10 shall be amended as follows:**

- 3A.6.10 The member's Nurse Care Manager shall provide a copy of the member's completed Integrated Plan of Health Care, including any updates, to the member, the member's guardian or conservator, as applicable, the HCBS Waiver ISC or Case Manager, and the member's community residential alternative provider, as applicable. The member's Nurse Care Manager/Care Management Support Team shall provide copies to other providers authorized to deliver care to the member upon request, and shall ensure that such physical and behavioral health care providers who do not receive a copy of the Integrated Plan of Health Care are informed in writing of all relevant information needed to ensure the provision of quality physical and behavioral health services for the member.



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39. **Section 3A.6.13 shall be amended as follows:**

3A.6.13 The CONTRACTOR shall provide to TENNCARE a report quarterly and/or upon request of all delays in service notices issued to participants in the Integrated Health Services Delivery Model, which shall specify at a minimum, the member's name and Medicaid ID, the type of service delayed, the date the service was authorized, the date the notice of delay was issued, the reason for the delay, and the projected date that the service will be available.

40. **Section 3A.7.1 shall be amended as follows:**

3A.7.1 The Nurse Care Manager shall reassess physical and behavioral health needs at least once every three hundred and sixty-five (365) days and within five (5) business days of the CONTRACTOR's becoming aware that the member's functional, physical, or behavioral status has changed significantly which may include, but is not limited to:

41. **Section 3A.7.3 and subsections thereto shall be amended as follows:**

3A.7.3 The reassessment shall occur at least once every three hundred and sixty-five (365) days, calculated either from the effective date of enrollment into the Integrated Health Services Delivery Model, or if an assessment occurs due to the CONTRACTOR's becoming aware that the member's functional, physical, or behavioral status has changed significantly, within three hundred and sixty-five (365) days of such assessment.

3A.7.3.1 For members who disenroll from and re-enroll into the Integrated Health Services Delivery Model within thirty (30) or less days, the reassessment shall occur as stated in Section 3A.7.3 above.

3A.7.3.2 For members who disenroll from and re-enroll into the Integrated Health Services Delivery Model after thirty-one (31) or more days, the member shall be assessed as a new enrollee and the reassessment date shall occur at least once every three hundred and sixty-five (365) days from the effective date of the re-enrollment or if an assessment occurs due to the CONTRACTOR's becoming aware that the member's functional, physical, or behavioral status has changed significantly, within 365 days of such assessment.

42. **Section 3A.9.3 shall be deleted in its entirety and the remaining Section 3A.9 shall be renumbered accordingly, including any references thereto.**

43. **Section 3A.10.2 shall be deleted and replaced as follows:**

3A.10.2 The CONTRACTOR shall monitor home health services, private duty nursing, and occupational, physical and speech therapy services covered under the TennCare 1115 Waiver program, to ensure such services are provided in accordance with the member's Integrated Plan of Health Care, including the amount, frequency, duration and scope of each service, in accordance with the member's service schedule; and that services continue to meet the member's needs



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44. **Section 3A.11 shall be amended by adding new subsection 3A.11.6 as follows:**

3A.11.6 The CONTRACTOR shall develop and implement processes related to TennCare disenrollment in a manner approved by TENNCARE.

45. **Section 3A.13.4 shall be amended as follows:**

3A.13.4 The CONTRACTOR shall use information regarding members gathered through assessment UM, and other processes as well as predictive modeling to help identify members with the most significant health and/or behavioral health needs who are at the highest risk and who offer the greatest potential for improvements in health outcomes, and to stratify members and prioritize Nurse Care Manager resources accordingly, such that individual Nurse Care Managers may have a greater or lesser number of assigned members based on the level of need of such members. The average Nurse Care Manager-to-member ratio shall not exceed 1:35 for members of the former Arlington class members who are not in an ICF/IID or other institutional placement and 1:50 for all other members.

46. **Section 3A.13.7 shall be amended as follows:**

3A.13.7 After the Integrated Health Services Delivery Model has been implemented, the CONTRACTOR shall notify TENNCARE in writing of substantive changes to its Nurse Care Management Staffing Plan, including a variance of twenty (20) percent or more from the Staffing Plan. TENNCARE may request changes in the CONTRACTOR's Nurse Care Management Staffing Plan at any time it determines that the CONTRACTOR does not have sufficient Nurse Care Management staff to properly and timely perform its obligations under this Contract.

47. **Section 3A.13.9 shall be amended as follows:**

3A.13.9 Nurse Care Managers shall be physically located within each Grand Region of the State to ensure proximity to the member and care providers. The CONTRACTOR shall ensure at least one (1) supervisor of Nurse Care Managers is located in each Grand Region. The CONTRACTOR shall report the location of each nurse care manager upon request.

48. **Section 3A.14.1.3 shall be amended as follows:**

3A.14.1.3 Section 1915(c) Waiver Programs for Persons with Intellectual Disabilities, including covered benefits and Independent Support Coordination or Case Management, as applicable;

49. **Section 3A.14.1.9 shall be deleted in its entirety and the remaining Section shall be renumbered accordingly, including any references thereto.**

50. **Section 3A.15.2 shall be amended as follows:**

3A.15.2 The CONTRACTOR shall, using a tool and methodology approved by TENNCARE, conduct annual consumer satisfaction surveys of all SelectCommunity members who are participating in the IHSD model, and shall provide such results to TENNCARE for review and dissemination.



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- 51. **Section 3A.16 shall be deleted in its entirety and the remaining Section 3A shall be renumbered accordingly, including any references thereto.**
- 52. **The previous Section 3A.17.1.8 shall be deleted in its entirety and the remaining renumbered Section 3A.16.1 shall be renumbered accordingly, including any references thereto.**
- 53. **The renumbered Section 3A.17 and all subsections thereto shall be deleted in their entirety and subsequent sections shall be renumbered accordingly.**
- 54. **Section 4.2 shall be amended by adding a new Section 4.2.5 as follows and the remaining Section 4.2 shall be renumbered accordingly, including any references thereto.**

4.2.5 HEDIS Measures (Beginning Reporting Year 2016)

4.2.5.1 Beginning with Reporting Year 2016, the following measures will be used for incentives through reporting year 2018. The measures are the following HEDIS measures and one EPSDT measure:

- 4.2.5.1.1 Timeliness of Prenatal Care;
- 4.2.5.1.2 Postpartum Care;
- 4.2.5.1.3 Medication Management for People with Asthma – seventy five percent (75%) measure;
- 4.2.5.1.4 Diabetes- Nephropathy, retinal exam, and BP <140/90;
- 4.2.5.1.5 Follow-up Care for Children Prescribed ADHD medication-initiation phase;
- 4.2.5.1.6 Follow-up Care for Children Prescribed ADHD Medication – continuation phase. Both initiation and continuation measures have to be calculated in order to receive quality incentive payment;
- 4.2.5.1.7 Adolescent well-care visits;
- 4.2.5.1.8 Immunizations for Adolescents – Combo 1;
- 4.2.5.1.9 Antidepressant Medication Management – acute and continuation;
- 4.2.5.1.10 EPSDT screening ratio ninety percent (90%) or above.

- 55. **The Liquidated Damages Chart in Section 5.20.2.2.7 shall be amended as follows:**

LEVEL	PROGRAM ISSUES	DAMAGE
A.16	Failure to comply with the timeframes for developing and approving a plan of care for transitioning CHOICES members in Group 2, authorizing and initiating	\$5,000 per month that the CONTRACTOR's performance is 85-89% by service setting (nursing facility or HCBS) \$10,000 per month that the CONTRACTOR's performance is 80-84% by service setting (nursing facility or HCBS)



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LEVEL	PROGRAM ISSUES	DAMAGE
	<p>nursing facility services for transitioning CHOICES members in Group 1, or initiating long-term care services for CHOICES members (see Sections 2.9.2, 2.9.3, and 2.9.6)</p>	<p>\$15,000 per month that the CONTRACTOR's performance is 75-79% by service setting (nursing facility or HCBS) \$20,000 per month that the CONTRACTOR's performance is 70-74% by service setting (nursing facility or HCBS) \$25,000 per month that the CONTRACTOR's performance is 69% or less by service setting (nursing facility or HCBS)</p> <p>These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing requirements as specified in Section 2.9.6.12.9 of this Contract</p> <p>TENNCARE may opt, at its discretion, to apply a \$500 per occurrence assessment in lieu of the methodology described above. This per occurrence amount shall be multiplied by two (2), totaling a \$1,000 per occurrence assessment when the CONTRACTOR has not complied with the Caseload and Staffing requirements as specified in Section 2.9.6.11.9 of this Contract</p>
<p>A.17(a)</p>	<p>Failure to meet the performance standards established by TENNCARE regarding missed visits for personal care, attendant care, or home-delivered meals for CHOICES members (referred to herein as "specified HCBS") for members in CHOICES Group 2 or 3</p>	<p>\$5,000 per month that 11-15% of visits are missed for a reason attributable to the provider (provider initiated), by specified HCBS \$10,000 per month that 16-20% of visits are missed for a reason attributable to the provider (provider initiated), by specified HCBS \$15,000 per month that 21-25% of visits are missed for a reason attributable to the provider (provider initiated), by specified HCBS \$20,000 per month that 26-30% of visits are missed for a reason attributable to the provider (provider initiated), by specified HCBS \$25,000 per month that 31% or more of visits are missed for a reason attributable to the provider (provider initiated), by specified HCBS</p>
<p>A.17(b)</p>	<p>Failure to conduct ongoing real-time monitoring of missed and late visits (see 2.9.6.9.2.1.9 and 2.9.6.12.1.11)</p>	<p>\$5,000 per occurrence</p>



Amendment 38 (cont.)

LEVEL	PROGRAM ISSUES	DAMAGE
A.17(c)	Failure to address service gaps, and ensure that back-up plans are implemented and effectively working (see 2.9.6.9.2.1.10 and 2.9.6.12.1.11)	\$5,000 per occurrence
B.19	Failure to comply with the timeframe for resolving complaints (see Section 2.19.2)	<p>\$1,000 per month that the CONTRACTOR's performance is 85-89%</p> <p>\$2,000 per month that the CONTRACTOR's performance is 80-84%</p> <p>\$3,000 per month that the CONTRACTOR's performance is 75-79%</p> <p>\$4,000 per month that the CONTRACTOR's performance is 70-74%</p> <p>\$5,000 per month that the CONTRACTOR's performance is 69% or less</p> <p>TENNCARE may opt, at its discretion, to apply a \$500 per occurrence assessment in lieu of the methodology described above</p>
B.23	Failure to meet any timeframe regarding care coordination for CHOICES members (see Sections 2.9.2, 2.9.3, 2.9.6, 2.9.6.2.3.4(4), 2.9.6.5.1.1, 2.9.6.10.2.1.2, 2.9.6.10.3, and 2.24.4.2.1) other than the timeframes referenced in Program Issues A.16 or A.17	<p>\$5,000 per month for each timeframe that the CONTRACTOR's performance is 85-89%</p> <p>\$10,000 per month for each timeframe that the CONTRACTOR's performance is 80-84%</p> <p>\$20,000 per month for each timeframe that the CONTRACTOR's performance is 75-79%</p> <p>\$50,000 per month for each timeframe that the CONTRACTOR's performance is 70-74%</p> <p>\$100,000 per month for each timeframe that the CONTRACTOR's performance is 69% or less</p> <p>These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing requirements as specified in Section 2.9.6.11.9 of this Contract.</p> <p>TENNCARE may opt, at its discretion, to apply a \$500 per occurrence assessment in lieu of the methodology described above. This per occurrence amount shall be multiplied by two (2), totaling a \$1,000 per occurrence assessment when the CONTRACTOR has not complied with the Caseload and Staffing requirements as specified in Section 2.9.6.11.9 of this Contract.</p>



C.1	Failure to comply in any way with staffing requirements as described in Section 2.29.1 of this Contract	TENNCARE may opt at its discretion to assess \$1,000.00 per calendar day, for each separate failure to comply with the required staffing requirements, from the first day of noncompliance through the thirtieth (30th) day of noncompliance. Additionally, at its discretion, TENNCARE may multiply this amount by two (2) for each day after thirty (30) calendar days for each specific instance that the CONTRACTOR fails to comply with the staffing requirements of the Contract.
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56. Section 5.40.6 shall be amended by deleting and replacing the website link as follows:

5.40.6 Loss or Suspected Loss of Data – If an employee of the CONTRACTOR becomes aware of suspected or actual loss of PHI/PII, he or she must immediately contact TENNCARE within one (1) hour to report the actual or suspected loss. The CONTRACTOR will use the Loss Worksheet located at http://tn.gov/assets/entities/tenncare/attachments/phi_piiworksheet.pdf to quickly gather and organize information about the incident. The CONTRACTOR must provide TENNCARE with timely updates as any additional information about the loss of PHI/PII becomes available.

57. The last line of Attachment VI shall be deleted and replaced as follows:

E-Mail Address: <http://tn.gov/tenncare/> (follow the prompts that read “Stop TennCare Fraud”)

58. Section A.3.3 of Attachment XI shall be amended by adding a new sentence to the end of the existing text as follows:

A.3.3 The CONTRACTOR shall not have a time limit for scheduling transportation for future appointments. For example, if a member calls to schedule transportation to an appointment that is scheduled in two (2) months, the CONTRACTOR shall arrange for that transportation and shall not require the member to call back at a later time. Members identified as a No Show and have been placed on probation may be required to call back at a later time.

59. Section A.5.1 of Attachment XI shall be amended by adding a new Section A.5.1.6 as follows:

A.5.1.6 Failure to comply with requirements regarding scheduling, assigning and dispatching trips may result in liquidated damages as provided in Section 5.20 of the Contract, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

60. Section A.8.3.7 of Attachment XI shall be deleted and replaced as follows:

A.8.3.7 The CONTRACTOR shall ensure that all drivers pass a drug test prior to providing services under the Contract. In addition, the CONTRACTOR shall ensure that an alcohol and drug test is conducted when a trained supervisor/employer of a driver has reasonable suspicion to



Amendment 38 (cont.)

believe that the driver has violated the CONTRACTOR's policies and procedures regarding use of alcohol and/or controlled substances, that random drug and alcohol tests are conducted, and that post accident drug and alcohol testing is conducted. The CONTRACTOR shall ensure that all drivers have been tested within the last five (5) years in the event they have not been randomly selected for testing. The CONTRACTOR's policies and procedures for drug and alcohol testing shall, at a minimum, meet the FMCSA's alcohol and drug testing requirements for motor carriers. Drivers should be randomly selected from the current utilized drivers for drug and alcohol testing with no less than twenty percent (20%) of drivers tested per calendar year. The drivers tested shall be reported to TENNCARE quarterly as described in the reporting section of this Attachment XI. Results of drug and alcohol testing shall be maintained in the driver's file as to allow for unscheduled file audits. All driver files (including but not limited to, HRAs, private vendor's, etc.) must contain an attestation signed by the driver containing the date of the drug and alcohol test if the actual test results cannot be provided.

61. **Section A.11.3 of Attachment XI shall be deleted and replaced as follows:**

A.11.3 Members shall not be charged for no-shows (as defined in Exhibit A of this Attachment). The CONTRACTOR shall monitor NEMT member no-shows and enforce the No-Show Policy provided to them by TENNCARE. Probation periods for non-compliant members shall be enforced as described in the policy. Failure to administer this policy and adhere to the probation notice requirements schedule shall result in liquidated damages as described in Exhibit F of this Attachment.

62. **Section A17.5.5 of Attachment XI shall be amended by deleting and replacing the reference to Section A.19.6.8 with Section A.19.5.8.**

63. **Section A.19.1 of Attachment XI shall be amended by adding a new Section A.19.1.5 as follows:**

A.19.1.5 No-Show Report. The CONTRACTOR shall submit a monthly no – show report utilizing the template provided by TENNCARE

64. **Definition number 9 in Exhibit A of Attachment XI shall be deleted and replaced as follows:**

9. **No-Show:** A trip is considered a no-show when the driver arrived on time, made his/her presence known, and the member cancels at the door or is not present five (5) minutes after the scheduled pick-up time.

65. **Item No. 2 in Exhibit F of Attachment XI shall be deleted and replaced as follows:**

No.	PERFORMANCE STANDARD	LIQUIDATED DAMAGE
2	Comply with the approval and scheduling requirements (see Section A.5.1 of this Attachment)	\$1,000 per deficiency



Amendment 38 (cont.)

66. **Exhibit F of Attachment XI shall be amended by adding new Items as follows:**

No.	PERFORMANCE STANDARD	LIQUIDATED DAMAGE
14	Failure by the CONTRACTOR to provide an acceptable Member Satisfaction Survey as required summarizing the methods and findings identifying opportunities for improvement in NEMT Services (see Sections A.17.5 and A.19.5.8 of this Attachment)	\$2500 for failure to provide an acceptable survey as required
15	Failure by the CONTRACTOR to enforce the Member No-Show Policy and adhere to the requirements of the policy provided to you by TENNCARE (see Section A.11.3 of this Attachment)	\$100 per occurrence for failure to follow the notification requirements of the No-Show Policy \$100 per occurrence for failure to follow the probationary requirements of the No-Show Policy \$100 per occurrence for failure to administer the No Show policy to a Non-Compliant Member reported to you by the driver

67. **Attachment XII shall be deleted in its entirety and the remaining attachments shall be renumbered accordingly, including any references thereto.**



Amendment 38 (cont.)

All of the provisions of the original Contract not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective January 1, 2016.

The State is not bound by this Amendment until it is signed by the contract parties and approved by appropriate officials in accordance with applicable Tennessee laws and regulations (depending upon the specifics of this Contract, said officials may include, but are not limited to, the Commissioner of Finance and Administration, the Commissioner of Human Resources, and the Comptroller of the Treasury).

The CONTRACTOR, by signature of this Amendment, hereby affirms that this Amendment has not been altered and therefore represents the identical document that was sent to the CONTRACTOR by TENNCARE.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

VOLUNTEER STATE HEALTH PLAN, INC.

BY: Larry B. Martin
Larry B. Martin
Commissioner

BY: Amber Cambron
Amber Cambron
President & CEO VSHP

DATE: 12/14/2015

DATE: 12/10/15

CONTRACT SUMMARY SHEET



RFS Number: 31866-00026	Edison # 29635	Contract Number: FA-02-14632-37
State Agency: Department of Finance and Administration		Division: Bureau of TennCare
Contractor: VSHP (TennCare Select)		Contract Identification No: Edison Vendor #0000071694

Service Description

Managed Care Organization / Medically Necessary Health Care Services to the TennCare/Medicaid Population

Contract Begin Date				Contract End Date		
7/1/2001				12/31/2016		
Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66		134	11	<input type="checkbox"/> STARS		
			Interdepartmental Funds	<input type="checkbox"/> Other Funding	Total Contract Amount (including ALL amendments)	
FY	State Funds	Federal Funds				
2002	\$ 6,755,937.23	\$ 11,843,931.25				\$ 18,599,868.48
2003	\$ 15,785,123.40	\$ 17,294,819.40				\$ 33,079,942.80
2004	\$ 25,125,990.72	\$ 38,364,165.90				\$ 63,490,156.62
2005	\$ 58,007,447.00	\$ 58,007,447.00				\$ 116,014,894.00
2006	\$ 87,748,111.00	\$ 87,748,111.00				\$ 175,496,222.00
2007	\$ 87,748,111.00	\$ 87,748,111.00				\$ 175,496,222.00
2008	\$ 72,610,000.00	\$ 127,390,000.00				\$ 200,000,000.00
2009	\$ 72,610,000.00	\$ 127,390,000.00				\$ 200,000,000.00
2010	\$ 100,882,479.00	\$ 304,024,121.00				\$ 404,906,600.00
2011	\$ 131,085,619.00	\$ 312,820,981.00				\$ 443,906,600.00
2012	\$ 149,893,942.00	\$ 294,012,658.00				\$ 443,906,600.00
2013	\$ 150,102,578.00	\$ 293,804,022.00				\$ 443,906,600.00
2014	\$ 153,147,777.00	\$ 290,758,823.00				\$ 443,906,600.00
2015	\$ 155,078,771.00	\$ 288,827,829.00				\$ 443,906,600.00
2016	\$ 155,211,942.69	\$ 288,694,657.31				\$ 443,906,600.00
2017	\$ 77,605,971.34	\$ 144,347,328.66				\$ 221,953,300.00
Total:	\$ 1,499,399,800.38	\$ 2,773,077,005.52				\$ 4,272,476,805.90

CFDA# 93.778 Title XIX Dept. of Health & Human Svcs.	Check the box ONLY if the answer is YES:
State Fiscal Contract	Is the Contractor a SUBRECIPIENT? (per OMB A-133)
Name: Casey Dungan Address: 310 Great Circle Road Nashville, TN Phone: (615)507-6482	Is the Contractor a Vendor? (per OMB A-133)
	Is the Fiscal Year Funding STRICTLY LIMITED?
Procuring Agency Budget Officer Approval Signature <i>[Signature]</i>	Is the Contractor on STARS?
Casey Dungan	Is the Contractor's FORM W-9 ATTACHED?
	Is the Contractor's Form W-9 Filed with Accounts?

COMPLETE FOR ALL AMENDMENTS (only)			Funding Certification
	Base Contract & Prior Amendments	This Amendment ONLY	Funding Certification (certification, required by T.C.A., § 9-4-5113, that there is a balance in the appropriation from which the obligated expenditure is required to be paid that is not otherwise encumbered to pay obligations previously incurred)
CONTRACT END DATE:	12/31/2015	12/31/2016	
FY: 2002	\$ 18,599,868.48		
FY: 2003	\$ 33,079,942.80		
FY: 2004	\$ 63,490,156.62		
FY: 2005	\$ 116,014,894.00		
FY: 2006	\$ 175,496,222.00		
FY: 2007	\$ 175,496,222.00		
FY: 2008	\$ 200,000,000.00		
FY: 2009	\$ 200,000,000.00		
FY: 2010	\$ 404,906,600.00		
FY: 2011	\$ 443,906,600.00		
FY: 2012	\$ 443,906,600.00		
FY: 2013	\$ 443,906,600.00		
FY: 2014	\$ 443,906,600.00		
FY: 2015	\$ 443,906,600.00		
FY: 2016	\$ 221,953,300.00	\$ 221,953,300.00	
FY: 2017	\$ -	\$ 221,953,300.00	
Total:	\$ 3,828,570,205.90	\$ 443,906,600.00	



AMENDMENT NUMBER 37
AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.

CONTRACT NUMBER: FA-02-14632-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as specified below.

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. **Section 2.7.2.8 shall be amended by adding new subsections 2.7.2.8.4 through 2.7.2.8.4.2 as follows:**

2.7.2.8.4 *Behavioral Crisis Prevention, Intervention, and Stabilization Services for Members with Intellectual or Developmental Disabilities (I/DD)*

2.7.2.8.4.1 The CONTRACTOR shall provide Behavioral Crisis Prevention, Intervention, and Stabilization Services for members with intellectual or developmental disabilities (I/DD). The CONTRACTOR shall develop and maintain a network of providers with sufficient experience and expertise in providing behavioral services to members with I/DD to assist and support the person or agency primarily responsible (whether paid or unpaid) for supporting a member with I/DD who is experiencing a behavioral crisis that presents a threat to the member's health and safety or the health and safety of others. Behavioral Crisis Prevention, Intervention, and Stabilization Services are typically initiated on-site at the crisis location to help prevent unnecessary institutional placement or psychiatric hospitalization. Such services shall include:

2.7.2.8.4.1.1 Assessing the nature of a crisis to determine whether the situation can be stabilized in the current location or if a more intensive level of intervention is necessary (e.g., behavioral respite, or when appropriate, inpatient mental health treatment);

2.7.2.8.4.1.2 Arranging the more intensive level of intervention when necessary;

2.7.2.8.4.1.3 Direction to those present at the crisis or direct intervention to de-escalate behavior or protect others in the immediate area;

2.7.2.8.4.1.4 Identification of potential triggers, including history of traumatic stress (as applicable), and development or refinement of interventions, including trauma informed care strategies, to address behaviors or issues that precipitated the behavioral crisis; and/or

2.7.2.8.4.1.5 Training and technical assistance to those who support the member on trauma informed care, crisis interventions, and strategies to mitigate issues that resulted in the crisis.



Amendment 37 (cont.)

- 2.7.2.8.4.2 The CONTRACTOR shall, pursuant to 2.30.8.1, report to TENNCARE the network of providers with experience and expertise in providing behavioral services to members with I/DD to deliver the services specified in 2.7.2.8.4.1 above.
2. **Section 2.7.7 shall be amended by adding a new Section 2.7.7.6 as follows:**
- 2.7.7.6 For all education activities required in this section pertaining to advance directives, the CONTRACTOR shall use materials provided by TENNCARE.
3. **Amendment 36 incorrectly identified Section 2.8.7 to be deleted and replaced. The correct Section reference to be replaced should have been 2.8.6. Sections 2.8.6 and 2.8.7 should read as follows:**
- 2.8.6 **Clinical Practice Guidelines**
- Population Health programs shall utilize evidence-based clinical practice guidelines that follow current NCQA QI 9 guidelines. A list of clinical practice guidelines for conditions referenced in Section 2.8.2.1.3.1 of this Contract, as well as Maternity, Obesity, and Preventive Services must be submitted for review by TENNCARE on an annual basis.
- 2.8.7 **Informing and educating Members**
- The CONTRACTOR shall inform all members of the availability of Population Health Programs and how to access and use the program services. The member shall be provided information regarding their eligibility to participate, how to self refer, and how to either appropriately “opt in” or “opt out” of a program.
4. **Section 2.9.4 and 2.9.4.1 shall be deleted and replaced as follows:**
- 2.9.4 **CHOICES Assessments for a CONTRACTOR’S Current Members Under the Age of Twenty-One**
- 2.9.4.1 When a member receiving home health or private duty nursing services in excess of specified benefit limits for adults is turning age twenty-one (21), the CONTRACTOR shall, at least sixty (60) days prior to the member’s 21st birthday, conduct an in-home assessment to determine whether the member is interested in applying for CHOICES, and if so, shall, pursuant to Section 2.9.7.3.8 conduct an in-home assessment and, subject to the member’s eligibility to enroll in CHOICES, coordinate with TENNCARE to help facilitate enrollment in CHOICES and initiation of CHOICES benefits on the member’s 21st birthday.
5. **Section 2.9.6.2.4 shall be amended by adding a new Section 2.9.6.2.4.6 as follows:**
- 2.9.6.2.4.6 Any time the CONTRACTOR submits a level of care application to TENNCARE for a member in a Nursing Facility, the CONTRACTOR shall, as expeditiously as possible and within no more than two (2) business days, notify the Nursing Facility that a level of care application has been submitted, and shall provide a copy of such application to the Nursing Facility.



6. **Section 2.9.6.5.2.2 shall be deleted and replaced as follows:**

2.9.6.5.2.2 At a minimum, for members in CHOICES Group 2 and 3, the comprehensive needs assessment shall assess: (1) the member's overall wellness including physical, behavioral, functional, and psychosocial needs, and an evaluation of the member's financial health as it relates to the member's ability to maintain a safe and healthy living environment, which for individuals receiving community-based residential alternative services other than companion care, shall include the member's capabilities and desires regarding personal funds management; any training or assistance needed to support the member in managing personal funds or to develop skills needed to increase independence with managing personal funds; and any health, safety or exploitation issues that require limitations on the member's access to personal funds; (2) the member's interest in pursuing integrated, competitive employment and any barriers to pursuing employment (as applicable); (3) the member's opportunities to engage in community life and access community services and activities to the same degree as individuals not receiving HCBS; (4) the member's natural supports, including care being provided by family members and/or other caregivers, and long-term care services the member is currently receiving (regardless of payor), and whether there is any anticipated change in the member's need for such care or services or the availability of such care or services from the current caregiver or payor; and (5) the physical health, behavioral health, and long-term care services and other social support services and assistance (e.g., housing or income assistance) that are needed, as applicable, to ensure the member's health safety and welfare in the community, delay or prevent the need for institutional placement, and to support the member's individually identified goals and outcomes, including employment (as applicable) and integrated community living.

7. **Section 2.9.6.6.2.4 and 2.9.6.6.2.5 through 2.9.6.6.2.5.14 shall be deleted and replaced by a combined Section 2.9.6.6.2.4 as follows. The remaining Section 2.9.6.6.2 shall be renumbered accordingly, including any references thereto.**

2.9.6.6.2.4. The plan of care developed for CHOICES members in Groups 2 and 3 prior to initiation of CHOICES HCBS shall be completed in accordance with federal rules at 42 C.F.R. § 441.301(c) pertaining to person-centered planning and with TENNCARE protocol and at a minimum shall include:

2.9.6.6.2.4.1 Pertinent demographic information regarding the member including the member's current address and phone number(s), the name and contact information of any representative and a list of other persons authorized by the member to have access to health care (including long-term care) related information and to assist with assessment, planning, and/or implementation of health care (including long-term care) related services and supports, (along with signed copies of all documents required in order to allow access to records or decision-making authority by the authorized representative(s), if applicable);

2.9.6.6.2.4.2 Documentation that the setting in which the member resides is chosen by the member and meets the HCBS Settings Rule requirements of 42 C.F.R. § 441.301(c)(4)-(5);

2.9.6.6.2.4.3 The member's strengths and interests;

2.9.6.6.2.4.4 Person-centered goals and objectives, including employment (as applicable) and integrated community living goals, and desired wellness, health, functional, and quality



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- of life outcomes for the member, and how CHOICES services are intended to help the member achieve these goals;
- 2.9.6.6.2.4.5 Risk factors for the member and measures in place to minimize them, including for any modification regarding the conditions set forth in the federal HCBS setting rule at 42 C.F.R. §§ 441.301(c)(4)(vi)(A) through (D), all of the documentation requirements specified at 42 C.F.R. §§ 441.301(c)(2)(xiii)(A-H) and 441.301(c)(4)(vi)(F)(1-8);
 - 2.9.6.6.2.4.6 Support, including specific tasks and functions that will be performed by family members and other caregivers;
 - 2.9.6.6.2.4.7 Caregiver training or supports identified through the caregiver assessment that are needed to support and sustain the caregiver's ability to provide care for the member;
 - 2.9.6.6.2.4.8 Home health, private duty nursing, and long-term care services the member will receive from other payor sources including the payor of such services;
 - 2.9.6.6.2.4.9 Home health and private duty nursing that will be authorized by the CONTRACTOR;
 - 2.9.6.6.2.4.10 CHOICES HCBS that will be authorized by the CONTRACTOR, including the amount, frequency, duration, and scope (tasks and functions to be performed) of each service to be provided, how such services should be delivered, including the member's preferences, the schedule at which such care is needed, and the address or phone number(s) that will be used to log visits into the EVV system, as applicable;
 - 2.9.6.6.2.4.11 A detailed back-up plan for situations when regularly scheduled HCBS providers are unavailable or do not arrive as scheduled; the back-up plan may include paid and unpaid supports and shall include the names and telephone numbers of persons and agencies to contact and the services provided by listed contacts; the CONTRACTOR shall assess the adequacy of the back-up plan;
 - 2.9.6.6.2.4.12 For CHOICES Group 2 members, the projected TennCare monthly and annual cost of home health and private duty nursing identified in 2.9.6.6.2.4.9 above, and the projected monthly and annual cost of CHOICES HCBS specified in 2.9.6.6.2.4.10 above, and for CHOICES Group 3 members, the projected total cost of CHOICES HCBS specified in 2.9.6.6.2.4.10 above, excluding the cost of minor home modifications;
 - 2.9.6.6.2.4.13 Description of the member's overall wellness, current physical and behavioral health conditions and functional status (i.e., areas of functional deficit), and the member's physical, behavioral and functional needs;
 - 2.9.6.6.2.4.14 Description of the member's physical environment and any modifications necessary to ensure the member's health and safety;
 - 2.9.6.6.2.4.15 Description of medical equipment used or needed by the member (if applicable);
 - 2.9.6.6.2.4.16 Description of any special communication needs including interpreters or special devices;
 - 2.9.6.6.2.4.17 A description of the member's psychosocial needs, including any housing or financial assistance needs which could impact the member's ability to maintain a safe and healthy



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living environment and how such needs will be addressed in order to ensure the member's ability to live safely in the community;

- 2.9.6.6.2.4.18 For persons receiving community-based residential alternative services other than companion care, a description of the member's capabilities and desires regarding personal funds management; the extent to which personal funds will be managed by the provider agency or the member's representative (as applicable); whether the member will have a separate bank account rather than an agency-controlled account for personal funds; any training or assistance that will be provided to support the member in managing personal funds or to develop skills needed to increase independence with managing personal funds; goals and objectives involving use of the member's personal funds; and any health, safety or exploitation issues that require limitations on the member's access to personal funds and strategies to remove limitations at the earliest possible time;
- 2.9.6.6.2.4.19 A person-centered statement of goals, objectives and desired wellness, health, functional and quality of life outcomes for the member and how CHOICES services are intended to help the member achieve these goals;
- 2.9.6.6.2.4.20 Description of other services that will be provided to the member, including (1) covered physical health services, including population health services, that will be provided by the CONTRACTOR to help the member maintain or improve his or her physical health status or functional abilities and maximize independence; (2) covered behavioral health services that will be provided by the CONTRACTOR to help the member maintain or improve his or her behavioral health status or functional abilities and maximize independence; (3) other psycho/social support services and assistance needed in order to ensure the member's health, safety and welfare, and as applicable, to delay or prevent the need for more expensive institutional placement; and (4) any non-covered services including services provided by other community resources, including plans to link the member to financial assistance programs including but not limited to housing, utilities and food as needed;
- 2.9.6.6.2.4.21 Relevant information regarding the member's physical health condition(s), including treatment and medication regimen, that is needed by a long-term care provider, caregiver or the care coordinator to ensure appropriate delivery of services or coordination of care;
- 2.9.6.6.2.4.22 Frequency of planned care coordinator contacts needed, which shall include consideration of the member's individualized needs and circumstances, and which shall at minimum meet required contacts as specified in Section 2.9.6.10.4 (unplanned care coordinator contacts shall be provided as needed);
- 2.9.6.6.2.4.23 Additional information for members who elect consumer direction of eligible CHOICES HCBS, including but not limited to whether the member requires a representative to participate in consumer direction and the specific services that will be consumer directed;
- 2.9.6.6.2.4.24 If the member chooses to self-direct any health care tasks, the type of tasks that will be self-directed;
- 2.9.6.6.2.4.25 Any steps the member and/or representative should take in the event of an emergency that differ from the standard emergency protocol;



Amendment 37 (cont.)

2.9.6.6.2.4.26 Planning what to do during an emergency shall include, but may not be limited to the following:

2.9.6.6.2.4.26.1 Developing an emergency plan;

2.9.6.6.2.4.26.2 Creating a plan to have shelter in place when appropriate;

2.9.6.6.2.4.26.3 Creating a plan to get to another safe place when appropriate; and

2.9.6.6.2.4.26.4 Identifying, when possible, two ways out of every room in case of fire.

2.9.6.6.2.4.27 Identify any additional steps the member and/or representative should take in the event of an emergency;

2.9.6.6.2.4.28 A disaster preparedness plan specific to the member; and

2.9.6.6.2.4.29 The member's TennCare eligibility end date.

8. **Section 2.9.6.6.2.6.4 shall be deleted and replaced as follows:**

2.9.6.6.2.6.4 Instances in which a member's signature is not required are limited to: 1) member-initiated schedule changes to the POC that do not alter the level of services (i.e. the amount, duration or type of services) detailed in the current POC for the member; 2) changes in the provider agency that will deliver services that do not alter the level of services (i.e. the amount, duration or type of services) detailed in the current POC for the member; however, all schedule changes must be member-initiated; 3) changes in the member's current address and phone number(s) or the phone number(s) or address that will be used to log visits into the EVV system; 4) the end of a member's participation in MFP at the conclusion of his 365-day participation period; or 5) instances as permitted pursuant to TennCare policies and protocols. Documentation of such changes shall be maintained in the member's records.

9. **Section 2.9.6.6.2.7 shall be deleted and replaced as follows:**

2.9.6.6.2.7 The member's care coordinator/care coordination team shall provide a copy of the member's completed plan of care, including any updates, to the member, the member's representative, as applicable, the member's community-based residential alternative provider, as applicable, and other providers authorized to deliver care to the member, , and shall ensure that each provider signs the plan of care indicating they understand and agree to provide the services as described prior to the schedule implementation of services and prior to any change in such services. The CONTRACTOR shall have mechanisms in place to ensure that such signatures and confirmation of each provider's agreement to provide services occurs within the timeframes specified in 2.9.6.3.12, 2.9.6.3.20, and 2.9.6.6.2.8, such that a delay in the initiation of services does not result. Electronic signatures will be accepted for providers who are not present during the care planning process or as needed to facilitate timely implementation, including updates to the plan of care based on the member's needs.



Amendment 37 (cont.)

10. **Section 2.9.6.8 shall be amended by adding a new Section 2.9.6.8.26 as follows and renumbering the remaining Section accordingly, including any references thereto.**

2.9.6.8.26 Any nursing facility to community transition shall be based on the individualized needs and preferences of the member. The CONTRACTOR shall not establish a minimum number of members on any care coordinator's caseload or a minimum number of residents of any facility that must be transitioned to the community. The CONTRACTOR shall ensure that care coordinators are screening members' potential for and interest in transition (see Section A.2.9.6.5.1.1) and when applicable, facilitating transition activities in a timely manner (see Section A.2.9.6.8), but shall not require any care coordinator as a condition of employment to identify a minimum number of nursing facility residents for transition to the community. Nor shall the CONTRACTOR pay any care coordinator an incentive or bonus based on the number of persons transitioned from a nursing facility to the community, unless there are appropriate safeguards, as determined and approved in writing by TENNCARE, to ensure that transitions are appropriate and consistent with the needs and preferences of residents.

11. **Section 2.9.6 shall be amended by adding new Sections 2.9.6.9 through 2.9.6.9.3 as follows and subsequent sections shall be renumbered accordingly, including any references thereto.**

2.9.6.9 **Community-Based Residential Alternative (CBRA) Services**

2.9.6.9.1 The CONTRACTOR shall authorize CBRA services and shall facilitate a member's transition into a CBRA service and a specific CBRA setting *only* when such service *and* setting have been selected by the member; the member has been given the opportunity to meet and to choose to reside with any housemates who will also live in the CBRA setting; and the setting has been determined to be appropriate for the member based on the member's needs, interests, and preferences.

2.9.6.9.2 Prior to transition of any CHOICES Group 2 or 3 member into a community-based residential alternative setting and the initiation of any community-based residential alternative services other than companion care (including assisted care living facility services, adult care homes, community living supports, and community living supports-family model), and prior to the transition of any CHOICES Group 2 or 3 member to a new community-based residential alternative services provider, the care coordinator shall visit the residence where the member will live and shall, in accordance with protocols developed by TENNCARE, conduct an on-site assessment of the proposed community-based residential alternative setting to ensure that the living environment and living situation are appropriate and that the member's needs will be safely and effectively met.



Amendment 37 (cont.)

2.9.6.9.3 Within the first twenty-four (24) hours of the transition of any CHOICES Group 2 or 3 member into a community-based residential alternative setting and the initiation of any community-based residential alternative services other than companion care (including assisted care living facility services, adult care homes, community living supports and community living supports-family model), and within the first twenty-four (24) hours of the transition of any CHOICES Group 2 or 3 member to a new community-based residential alternative services provider, the care coordinator shall contact the member and within seven (7) days after the member has transitioned, the care coordinator shall visit the member in his/her new residence to confirm the member's satisfaction with the CBRA provider, and services; that the plan of care is being implemented; that the services are being delivered in a manner that is consistent with the member's preferences and which supports the member in achieving his or her goals and desired outcomes; and that the member's needs are safely and effectively met. Such contacts may be completed by a member of the Transition Team who meets all of the requirements to be a care coordinator.

12. **The renumbered Section 2.9.6.10.2.1.9 shall be deleted and replaced as follows:**

2.9.6.10.2.1.9 Upon the scheduled initiation of services identified in the plan of care, the member's care coordinator/care coordination team shall begin monitoring to ensure that services have been initiated and continue to be provided as authorized and in accordance with the member's plan of care. This shall include ongoing monitoring via electronic visit verification to ensure that services are provided in accordance with the member's plan of care, including the amount, frequency, duration and scope of each service, in accordance with the member's service schedule; and that services continue to meet the member's needs. It shall also include in-person monitoring of the quality of such services, the member's satisfaction with the services, and whether the services are being delivered in a manner that is consistent with the member's preferences and which supports the member in achieving his or her goals and desired outcomes;

13. **The renumbered Section 2.9.6.10.3 shall be amended by adding new Sections 2.9.6.10.3.7 through 2.9.6.10.3.7.13 as follows. The remaining Section 2.9.6.10.3 shall be renumbered accordingly, including any references thereto.**

2.9.6.10.3.7 For members receiving community-based residential alternative services, other than assisted care living facility services or companion care, including adult care homes, community living supports and community living supports-family model, the CONTRACTOR shall ensure that at each face-to-face visit the care coordinator makes the following observations, in addition to those observations required in Section 2.9.6.10.3.6, documents such observations in the member's file, takes immediate actions necessary to address any concern(s) identified based on such observations, and documents resolution of the concern(s) in the member's file:

2.9.6.10.3.7.1 A copy of the plan of care is accessible in the home to all caregivers;

2.9.6.10.3.7.2 The plan of care is being implemented and services are being delivered in a manner that is consistent with the member's preferences and which supports the member in achieving his or her goals and desired outcomes;

2.9.6.10.3.7.3 The member is able to make his or her own choices and maintains control of his or her home and environment;



Amendment 37 (cont.)

- 2.9.6.10.3.7.4 The member is supported in participating fully in community life, including faith-based, social, and leisure activities selected by the individual;
- 2.9.6.10.3.7.5 The member maintains good relationships with housemates, and there are no major, unresolved disputes;
- 2.9.6.10.3.7.6 There is an adequate food supply for the member that is consistent with the member's dietary needs and preferences;
- 2.9.6.10.3.7.7 All utilities are working and in proper order;
- 2.9.6.10.3.7.8 For members whose plan of care reflects that the provider will manage the member's personal funds, review financial records and statements to ensure member's bills have been paid timely and are not overdue, and that there are adequate funds remaining for food, utilities, and any other necessary expenses;
- 2.9.6.10.3.7.9 For members who require 24/7 staff, that such staff are in the residence during the visit and attentive to the member's needs and interests;
- 2.9.6.10.3.7.10 The member has been properly supported in scheduling and attending any medical appointments, as applicable;
- 2.9.6.10.3.7.11 Any medications administered by the staff pursuant to T.C.A. §§ 68-1-904 and 71-5-1414 are documented in a Medication Administration Record in accordance with the member's prescriptions, and that any medication errors have been reported;
- 2.9.6.10.3.7.12 The member's chronic health conditions, as applicable, are being properly managed, and in the case of members receiving CLS 3 or CLS-FM 3, nurse oversight and monitoring, and skilled nursing services are being provided, as appropriate, and as reflected in the member's plan of care for routine, ongoing health care tasks, such as blood sugar monitoring and management, oral suctioning, tube feeding, bowel care, etc.; and
- 2.9.6.10.3.7.13 Any other requirements specified in TennCare policies and protocols.

14. **The renumbered Sections 2.9.6.10.4.3.7, 2.9.6.10.4.3.8, and 2.9.6.10.4.3.9 shall be deleted and replaced and a new subsection 2.9.6.10.4.3.10 shall be added as follows:**

- 2.9.6.10.4.3.7 Except as specified in 2.9.6.10.4.3.10 below, members in CHOICES Group 2 shall be contacted by their care coordinator at least monthly either in person or by telephone with an interval of at least fourteen (14) days between contacts. These members shall be visited in their residence face-to-face by their care coordinator at least quarterly with an interval of at least sixty (60) days between visits.
- 2.9.6.10.4.3.8 Except as specified in 2.9.6.10.4.3.10 below, members in CHOICES Group 3 shall be contacted by their care coordinator at least quarterly (more frequently when appropriate based on the member's needs and/or request which shall be documented in the plan of care). Such contacts shall be either in person or by telephone with an interval of at least sixty (60) days between contacts. These members shall be visited in their residence face-



Amendment 37 (cont.)

to-face by their care coordinator at least semi-annually (more frequently when appropriate based on the member's needs and/or request which shall be documented in the plan of care) with an interval of at least one hundred-twenty (120) days between visits.

2.9.6.10.4.3.9 Except as specified in 2.9.6.10.4.3.10 below, members in CHOICES Group 2 participating in MFP shall, for at least the first ninety (90) days following transition to the community, be visited in their residence face-to-face by their care coordinator at least monthly with an interval of at least fourteen (14) days between contacts to ensure that the plan of care is being followed, that the plan of care continues to meet the member's needs, and the member has successfully transitioned back to the community. Thereafter, for the remainder of the member's MFP participation period, minimum contacts shall be as described in Section 2.9.6.10.4.3.7 unless more frequent contacts are required based on the member's needs and circumstances and as reflected in the member's plan of care, or based on a significant change in circumstances (see Sections 2.9.6.1.2.1.17 and 2.9.8.4.5) or a short-term nursing facility stay (see Sections 2.9.8.8.5 and 2.9.8.8.7).

2.9.6.10.4.3.10 Members in CHOICES Group 2 or 3 receiving community-based residential alternative services, other than assisted care living facility services or companion care, including adult care homes, community living supports, and community living supports-family model, shall be visited in their residence face-to-face by their care coordinator at least monthly with an interval of at least fourteen (14) days between contacts to ensure that the plan of care is being followed and that the plan of care continues to meet the member's needs, unless more frequent contacts are required based on the member's needs and circumstances and as reflected in the member's plan of care, based on a significant change in circumstances (see Sections 2.9.6.10.2.1.17 and 2.9.8.4.5), or a short-term nursing facility stay (see Sections 2.9.8.8.5 and 2.9.8.8.7).

15. **Section 2.11.8.3 shall be deleted and replaced as follows:**

2.11.8.3 Local Health Departments

The CONTRACTOR shall contract with each local health department in each Grand Region(s) served by the CONTRACTOR for the provision of TENNderCare screening services until such time as the CONTRACTOR achieves a TENNderCare screening percentage of eighty percent (80%) or greater. Payment to local health departments shall be in accordance with Section 2.13.7.

16. **Section 2.11.9.4.1.2.5.1. shall be deleted and replaced as follows:**

2.11.9.4.1.2.5.1 Delivering person-centered supports for older adults and adults with physical disabilities;

17. **Section 2.11.9.4.1.2 shall be amended by adding a new Section 2.11.9.4.1.2.7 as follows:**

2.11.9.4.1.2.7 Is compliant with the HCBS Settings Rule detailed in 42 C.F.R. § 441.301(c)(4)- (5).



Amendment 37 (cont.)

18. **Section 2.11.9.4.1.3 shall be deleted and replaced as follows:**

2.11.9.4.1.3 At a minimum, recredentialing of HCBS providers shall include verification of continued licensure and/or certification (as applicable); compliance with policies and procedures identified during credentialing, including background checks and training requirements, critical incident reporting and management, and use of the EVV; and compliance with the HCBS Settings Rule detailed in 42 C.F.R. § 441.301(c)(4)-(5).

19. **The opening paragraph of Section 2.12.11 shall be deleted and replaced as follows:**

A.2.12.11 Prior to executing a provider agreement with any CHOICES HCBS provider seeking Medicaid reimbursement for CHOICES HCBS, the CONTRACTOR shall verify that the provider is compliant with the HCBS Settings Rule detailed in 42 C.F.R. § 441.301(c)(4)-(5). The provider agreement with a CHOICES HCBS provider shall meet the minimum requirements specified in Section 2.12.9 above and shall also include, at a minimum, the following requirements:

20. **Section 2.12.11 shall be amended by adding new subsection 2.12.11.15 as follows:**

2.12.11.15 The CONTRACTOR shall require that all CHOICES HCBS providers maintain compliance with the HCBS Settings Rule detailed in 42 C.F.R. § 441.301(c)(4)-(5).

21. **Section A.2.13.3 shall be deleted in its entirety and replaced as follows:**

A.2.13.3 **All Covered Services**

2.13.3.1 Except as provided in Sections A.2.13.3.1.1 and A.2.13.3.1.2 below, the CONTRACTOR shall not reimburse providers based on a percentage of billed charges.

2.13.3.1.1 The CONTRACTOR may, at its discretion, pay a percentage of billed charges for covered physical health and behavioral health services for which there is no Medicare reimbursement methodology.

2.13.3.1.2 As part of a stop-loss arrangement with a physical health or behavioral health provider, the CONTRACTOR may, at its discretion, pay the provider a percentage of billed charges for claims that exceed the applicable stop-loss threshold.

2.13.3.2 The CONTRACTOR shall not reimburse providers based on automatic escalators or linkages to other methodologies that escalate such as current Medicare rates or inflation indexes unless otherwise allowed by TENNCARE.

22. **Sections 2.15.7.1.1, 2.15.7.1.3 and 2.15.7.1.3.1 shall be deleted and replaced as follows:**

2.15.7.1.1 The CONTRACTOR shall develop and implement a critical incident reporting and management system for incidents that occur in a home and community-based long-term care service delivery setting, including: community-based residential alternatives; adult day care centers; other CHOICES HCBS provider sites; and a member's home or any other community-based setting, if the incident occurs during the provision of covered CHOICES HCBS.



Amendment 37 (cont.)

2.15.7.1.3 Critical incidents shall include but not be limited to the following incidents when they occur in a home and community-based long-term care service delivery setting (as defined in Section 2.15.7.1.1 above), regardless of whether the provider is believed to be responsible for the incident:

2.15.7.1.3.1 Any unexpected death of a CHOICES member, regardless of whether the death occurs during the provision of HCBS;

23. **Section A.2.15.7.3.1 shall be deleted and replaced as follows:**

2.15.7.3.1 The CONTRACTOR shall identify, track, and review all significant critical incidents that occur during the provision of Home Health (HH) services. This requirement shall be applied for all members, including CHOICES and non-CHOICES members. A HH critical incident shall include those significant incidents that are reported to the CONTRACTOR from the HH including unexpected death, major/severe injury, safety issues, or suspected physical, mental or sexual abuse or neglect. Each incident must be reported using the TENNCARE prescribed HHA Critical Incident report template within twenty-four (24) hours of the CONTRACTOR QM/QI Program staff receiving information relative to such an incident. An updated report, including results of investigation and next steps must be submitted to TENNCARE within thirty (30) calendar days of notification of the incident. The CONTRACTOR shall be responsible, as part of its critical incident management system, to track, review and analyze critical incident data in a manner described in Section A.2.15.7.1.2 that takes into consideration all incidents occurring for members supported by an agency, whether they occur during the provision of CHOICES HCBS or HH services, including the identification of trends and patterns, opportunities for improvement, and actions and strategies the CONTRACTOR will take to reduce the occurrence of incidents and improve the quality of HH services received.

24. **Section 2.18.6.10 shall be deleted and replaced as follows:**

2.18.6.10 The CONTRACTOR shall conduct ongoing provider education, training and technical assistance as deemed necessary by the CONTRACTOR or TENNCARE in order to ensure compliance with this Contract. This shall include training and technical assistance in person-centered supports and compliance with the HCBS settings rule, as directed and/or approved by TENNCARE.

25. **Section 2.30.4 shall be amended by adding a new Section 2.30.4.5 as follows:**

2.30.4.5 The CONTRACTOR shall submit a quarterly *Behavioral Crisis Prevention, Intervention, and Stabilization Services for Individuals with Intellectual or Developmental Disabilities (I/DD) Report* including the data elements described by TENNCARE. Specified data elements shall be reported for each individual provider as described in the template provided by TENNCARE.



Amendment 37 (cont.)

26. **Section 2.30.5.3 shall be deleted and replaced as follows:**

2.30.5.3 The CONTRACTOR shall submit annually, on July 1, a *Population Health Annual Report* in the format described in the annual report template provided by TENNCARE. The report shall include active participation rates, as designated by NCQA, for programs with active interventions. Short term and intermediate outcome data reporting is required. Member satisfaction shall be reported based upon NCQA requirements along with functional status for members in the Chronic Care Management and Complex Case Management programs.

27. **Section 2.30.6.9 shall be deleted and replaced as follows:**

2.30.6.9 Upon notification from TENNCARE, the CONTRACTOR shall submit a monthly MFP Participants Report. The report shall include information on specified measures, which shall include but not be limited to the following:

2.30.6.9.1 The total number and the name and SSN of each CHOICES Group 2 or Group 3 member enrolled into MFP;

2.30.6.9.2 The date of each member's transition to the community (or for persons enrolled in MFP upon enrollment to the CONTRACTOR's health plan, the date of enrollment into the CONTRACTOR's health plan);

2.30.6.9.3 Each member's current place of residence including physical address and type of Qualified Residence;

2.30.6.9.4 The date of the last care coordination visit to each member;

2.30.6.9.5 Any inpatient facility stays during the month, including the member's name and SSN type of Qualified Institution, dates of admission and discharge, and the reason for admission; and

2.30.6.9.6 The total number and name and SSN of each member disenrolled from MFP during the month, including the reason for disenrollment.

28. **Sections 2.30.6.10 and 11 shall be deleted and replaced as follows:**

2.30.6.10 The CONTRACTOR shall submit a listing of members identified as potential pharmacy lock-in candidates (see Section A.2.9.11.3.2) twice a year on June 1 and December 1, according to the following parameters:

2.30.6.10.1 Members with at least 3 controlled substances in a three-month period, and

2.30.6.10.2 at least 3 different pharmacies, and

2.30.6.10.3 at least 3 different emergency room prescribers.

2.30.6.11 The CONTRACTOR shall submit a quarterly Pharmacy Services Report on the prescribing of selected medications mutually agreed-upon by TENNCARE and the CONTRACTOR and includes a list of the providers who appear to be operating outside industry or peer norms as defined by TENNCARE or have been identified as non-compliant as it relates to adherence to



Amendment 37 (cont.)

accepted treatment guidelines for use of said medications and the steps the CONTRACTOR has taken to personally intervene with each one of the identified providers as well as the outcome of these personal contacts.

29. **Section 2.30.8.1 shall be deleted and replaced as follows:**

2.30.8.1 The CONTRACTOR shall submit a monthly Provider Enrollment File that includes information on all providers of TennCare health services, including physical, behavioral health, and long-term care providers (see Section 2.11). This includes but is not limited to, PCPs, physician specialists, hospitals, home health agencies, CMHAs, nursing facilities, CHOICES HCBS providers, and emergency and non-emergency transportation providers. For CHOICES HCBS providers, the Provider Enrollment File shall identify the type(s) of CHOICES HCBS the provider is contracted to provide and the specific counties in which the provider is contracted to deliver CHOICES HCBS, by service type. For Behavioral Crisis Prevention, Intervention, and Stabilization Services for Individuals with Intellectual or Developmental Disabilities (see Section 2.7.2.8.4), the report shall specify the specific counties in which the provider is contracted to deliver such services. The report shall include contract providers as well as all non-contract providers with whom the CONTRACTOR has a relationship. During any period of readiness review, the CONTRACTOR shall submit this report as requested by TENNCARE. Each monthly Provider Enrollment File shall include information on all providers of covered services and shall provide a complete replacement for any previous Provider Enrollment File submission. Any changes in a provider's contract status from the previous submission shall be indicated in the file generated in the month the change became effective and shall be submitted in the next monthly file.

30. **Amendment 36 inadvertently amended Section 4.9.1 instead of 4.10.1. Sections 4.9.1 and 4.10.1 shall be deleted and replaced as follows:**

4.9.1 TENNCARE shall make a payment to the CONTRACTOR in an amount equal to the invoice that is billed to the CONTRACTOR by the TennCare PBM. The CONTRACTOR shall make payment to the TennCare PBM no later than the Friday following receipt of the payment from TENNCARE unless extended by TENNCARE due to unforeseen circumstances or bank holidays.

4.10.1 In no event shall the maximum liability of the State under this Agreement during the original term of the Contract exceed four billion, two hundred seventy two million, four hundred seventy six thousand, eight hundred five dollars and ninety cents (\$4,272,476,805.90).

31. **Section 5.2.1 shall be amended as follows:**

5.2.1 This Agreement, and its incorporated attachments, if any, as well as all Amendments to this Agreement, contain all of the terms and conditions agreed upon by the parties, and when executed by all parties, supersedes any prior agreements. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall be in effect from July 1, 2001, subject to approval by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The term of this Agreement shall expire on December 31, 2016. At the mutual agreement of TENNCARE and the CONTRACTOR, this Agreement shall be renewable for an additional twelve month period.



Amendment 37 (cont.)

32. **Section 5.3 shall be amended by adding new Sections 5.3.48 and 5.3.49 as follows:**

- 5.3.48 The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) as amended by PPACA.
- 5.3.49 The minimum and maximum hospital aggregate reimbursement levels as defined in Public Chapter 276, "The Annual Coverage Assessment Act of 2015".



Amendment 37 (cont.)

All of the provisions of the original Contract not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective July 1, 2015.

The State is not bound by this Amendment until it is signed by the contract parties and approved by appropriate officials in accordance with applicable Tennessee laws and regulations (depending upon the specifics of this Contract, said officials may include, but are not limited to, the Commissioner of Finance and Administration, the Commissioner of Human Resources, and the Comptroller of the Treasury).

The CONTRACTOR, by signature of this Amendment, hereby affirms that this Amendment has not been altered and therefore represents the identical document that was sent to the CONTRACTOR by TENNCARE.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

BY: Larry B. Martin
Larry B. Martin
Commissioner

DATE: 6/18/2015

VOLUNTEER STATE HEALTH PLAN, INC.

BY: Amber Cambron
Amber Cambron
President & CEO VSHP

DATE: 6/15/15

CONTRACT SUMMARY SHEET



RFS Number:	31866-00026	Edison #	29635	Contract Number:	FA-02-14632-36
State Agency:	Department of Finance and Administration			Division:	Bureau of TennCare
Contractor				Contract Identification Number	
VSHP (TennCare Select)				<input type="checkbox"/> V- <input type="checkbox"/> C-	Edison Vendor #0000071694

Service Description

Managed Care Organization / Medically Necessary Health Care Services to the TennCare/Medicaid Population

Contract Begin Date	Contract End Date
7/1/2001	12/31/2015

Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66		134	11	<input type="checkbox"/> STARS		
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)	
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$ 18,599,868.48	
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$ 33,079,942.80	
2004	\$ 25,125,990.72	\$ 38,364,165.90			\$ 63,490,156.62	
2005	\$ 58,007,447.00	\$ 58,007,447.00			\$ 116,014,894.00	
2006	\$ 87,748,111.00	\$ 87,748,111.00			\$ 175,496,222.00	
2007	\$ 87,748,111.00	\$ 87,748,111.00			\$ 175,496,222.00	
2008	\$ 72,610,000.00	\$ 127,390,000.00			\$ 200,000,000.00	
2009	\$ 72,610,000.00	\$ 127,390,000.00			\$ 200,000,000.00	
2010	\$ 100,882,479.00	\$ 304,024,121.00			\$ 404,906,600.00	
2011	\$ 131,085,619.00	\$ 312,820,981.00			\$ 443,906,600.00	
2012	\$ 149,893,942.00	\$ 294,012,658.00			\$ 443,906,600.00	
2013	\$ 150,102,578.00	\$ 293,804,022.00			\$ 443,906,600.00	
2014	\$ 153,147,777.00	\$ 290,758,823.00			\$ 443,906,600.00	
2015	\$ 155,078,771.00	\$ 288,827,829.00			\$ 443,906,600.00	
2016	\$ 77,539,385.00	\$ 144,413,915.00			\$ 221,953,300.00	
Total:	\$ 1,344,121,271.35	\$ 2,484,448,934.55			\$ 3,828,570,205.90	

CFDA#	93.778 Title XIX Dept. of Health & Human Svcs.	Check the box ONLY if the answer is YES:	
State Fiscal Contract		Is the Contractor a SUBRECIPIENT? (per OMB A-133)	
Name:	Casey Dungan	Is the Contractor a Vendor? (per OMB A-133)	
Address:	310 Great Circle Road Nashville, TN	Is the Fiscal Year Funding STRICTLY LIMITED?	
Phone:	(615)507-6482	Is the Contractor on STARS?	
Procuring Agency Budget Officer Approval Signature		Is the Contractor's FORM W-9 ATTACHED?	
Casey Dungan		Is the Contractor's Form W-9 Filed with Accounts?	

COMPLETE FOR ALL AMENDMENTS (only)			Funding Certification
	Base Contract & Prior Amendments	This Amendment ONLY	Funding Certification (certification, required by T.C.A., § 9-4-5113, that there is a balance in the appropriation from which the obligated expenditure is required to be paid that is not otherwise encumbered to pay obligations previously incurred)
CONTRACT END DATE:	12/31/2014	12/31/2015	
FY: 2002	\$ 18,599,868.48		
FY: 2003	\$ 33,079,942.80		
FY: 2004	\$ 63,490,156.62		
FY: 2005	\$ 116,014,894.00		
FY: 2006	\$ 175,496,222.00		
FY: 2007	\$ 175,496,222.00		
FY: 2008	\$ 200,000,000.00		
FY: 2009	\$ 200,000,000.00		
FY: 2010	\$ 404,906,600.00		
FY: 2011	\$ 443,906,600.00		
FY: 2012	\$ 443,906,600.00		
FY: 2013	\$ 443,906,600.00		
FY: 2014	\$ 443,906,600.00		
FY: 2015	\$ 221,953,300.00	\$ 221,953,300.00	
FY: 2016	\$ -	\$ 221,953,300.00	
Total:	\$ 3,384,663,605.90	\$ 443,906,600.00	



AMENDMENT NUMBER 36
AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.

CONTRACT NUMBER: FA-02-14632-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as specified below.

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. Section 1 shall be amended by deleting and replacing the following definitions:

At-Risk – As it relates to the CHOICES program, SSI eligible adults age sixty-five (65) and older or age twenty-one (21) or older with physical disabilities, who do not meet the established level of care criteria for nursing facility services, but have a lesser number or level of functional deficits in activities of daily living as defined in TennCare rules and regulations, such that, in the absence of the provision of a moderate level of home and community based services, the individual's condition and/or ability to continue living in the community will likely deteriorate, resulting in the need for more expensive institutional placement. As it relates to Interim CHOICES Group 3, open for enrollment only between July 1, 2012 and June 30, 2015, "at risk" is defined as adults age sixty-five (65) and older or age twenty-one (21) or older with physical disabilities who receive SSI or meet Nursing Financial eligibility criteria, and also meet the Nursing Facility level of care in effect on June 30, 2012

Care Coordination Team – If an MCO elects to use a care coordination team, the care coordination team shall consist of a care coordinator and specific other persons with relevant expertise and experience who are assigned to support the care coordinator in the performance of care coordination activities for a CHOICES member as specified in this Contract and in accordance with Section 2.9.6, but shall not perform activities that must be performed by the Care Coordinator, including needs assessment, caregiver assessment, development of the plan of care, and minimum Care Coordination contacts.

CHOICES At-Risk Demonstration Group – Individuals who are age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who (1) meet nursing home financial eligibility for TennCare-reimbursed long term services and supports, (2) meet the nursing facility level of care in place on June 30, 2012, but not the nursing facility level of care criteria in place on July 1, 2012; and (3) in the absence of TENNCARE CHOICES HCBS available through CHOICES Group 3, are At Risk for Institutionalization as defined in TennCare Rules. The CHOICES At-Risk Demonstration Group is open only between July 1, 2012, through June 30, 2015. Individuals enrolled in the CHOICES At-Risk Demonstration Group as of June 30, 2015, may continue to qualify in this group after June 30, 2015 so long as they (1) continue to meet Nursing Facility financial eligibility and the LOC criteria in place when they enrolled; and (2) remain continuously enrolled in the CHOICES At-Risk Demonstration Group and in CHOICES 3.



Amendment 36 (cont.)

CHOICES Group (Group) – One of the three groups of TennCare enrollees who are enrolled in CHOICES. There are three CHOICES groups:

Group 1

Medicaid enrollees of all ages who are receiving Medicaid-reimbursed care in a nursing facility.

Group 2

Persons age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who meet the nursing facility level of care, who qualify for TennCare either as SSI recipients or as members of the CHOICES 217-Like HCBS Group, and who need and are receiving CHOICES HCBS as an alternative to nursing facility care. The CHOICES 217-Like HCBS Group includes persons who could have been eligible under 42 CFR 435.217 had the state continued its 1915(c) HCBS waiver for elders and/or persons with physical disabilities. TENNCARE has the discretion to apply an enrollment target to this group, as described in TennCare rules and regulations.

Group 3

Persons age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who qualify for TennCare as SSI recipients, who do not meet the nursing facility level of care, but who, in the absence of CHOICES HCBS, are “at-risk” for nursing facility care, as defined by the State. TENNCARE has the discretion to apply an enrollment target to this group as described in TennCare rules and regulations.

Interim Group 3 (open for new enrollment only between July 1, 2012, through June 30, 2015)

Persons age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who qualify for TennCare as SSI eligibles or as members of CHOICES At-Risk Demonstration Group and who meet the NF LOC criteria in place as of June 30, 2012. There is no enrollment target on Interim Group 3.

All requirements set forth in this Contract regarding Group 3 members are applicable to Interim Group 3 members, except as explicitly stated otherwise. Interim Group 3 members are not subject to an enrollment target.

Community-Based Residential Alternatives to Institutional Care (Community-Based Residential Alternatives) – Residential services that offer a cost-effective, community-based alternative to nursing facility care for persons who are elderly and/or adults with physical disabilities. This includes, but is not limited to, community living supports, community living supports-family model, assisted care living facility services, critical adult care homes, and companion care. As provided in Section 2.6 of this Agreement, community-based residential alternatives shall be available to members in CHOICES Group 2.

Eligible Individual – With respect to Tennessee’s Money Follows the Person Rebalancing Demonstration (MFP) and pursuant to Section 6071(b)(2) of the Deficit Reduction Act of 2005 (DRA), (Pub. L. 109-171 (S. 1932)) (Feb. 8, 2006) as amended by Section 2403 of the Patient Protection and Affordable Care Act of 2010 (ACA), (Pub. L. 111-148) (May 1, 2010), the State’s approved MFP Operational Protocol and TennCare Rules, a member who qualifies to participate in MFP. Such person, immediately before beginning participation in the MFP demonstration project, shall:

1. Reside in a Qualified Institution, i.e., a Nursing Facility (NF), hospital, or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), and have resided in any combination of such Qualified Institutions for a period of not less than ninety (90) consecutive days.



Amendment 36 (cont.)

- a. Inpatient days in an institution for mental diseases (IMDs) which includes Psychiatric Hospitals and Psychiatric Residential Treatment Facilities (PRTF) may be counted only to the extent that Medicaid reimbursement is available under the State Medicaid plan for services provided by such institution. Medicaid payments may only be applied to persons in IMDs who are over 65 or under 21 years of age.
 - b. Any days that an individual resides in a Medicare certified Skilled Nursing Facility (SNF) on the basis of having been admitted solely for purposes of receiving post-hospital short-term rehabilitative services covered by Medicare shall not be counted for purposes of meeting the ninety (90)-day minimum stay in a Qualified Institution established under ACA.
 - c. Short-term continuous care in a nursing facility, to include Level 2 nursing facility reimbursement, for episodic conditions to stabilize a condition rather than admit to hospital or to facilitate hospital discharge, and inpatient rehabilitation facility services reimbursed by the CONTRACTOR (i.e., not covered by Medicare) as a cost-effective alternative (Refer to Section 2.6.5) and provided in a Qualified Institution shall be counted for purposes of meeting the ninety (90) day minimum stay in a Qualified Institution established under ACA.
2. For purposes of this Contract, an Eligible Individual must reside in a Qualified Institution and be eligible to enroll and transition seamlessly into CHOICES Group 2, or one of the 1915(c) HCBS Waivers, without delay or interruption.
 3. Meet nursing facility or ICF/IID level of care, as applicable, and, but for the provision of ongoing CHOICES HCBS, continue to require such level of care provided in an inpatient facility.

MOE Demonstration Group – Individuals who are age 65 and older and adults age 21 and older with disabilities who (1) meet nursing home financial eligibility, (2) do not meet the nursing facility level of care criteria in place on July 1, 2012; and (3) in the absence of TennCare CHOICES services, are “at risk” of institutionalization. The MOE Demonstration Group is open only between July 1, 2012, through June 30, 2015. Individuals enrolled in the MOE Demonstration Group as of June 30, 2015, may continue to qualify in this group after June 30, 2015, so long as they (1) continue to meet Nursing Facility financial eligibility and the LOC criteria in place when they enrolled; and (2) remain continuously enrolled in the MOE Demonstration Group and in CHOICES 3.

Money Follows the Person Rebalancing Demonstration (MFP) – A federal grant established under the Deficit Reduction Act and extended under the Affordable Care Act that will assist Tennessee in transitioning Eligible Individuals from a Qualified Institution into a Qualified Residence in the community and in rebalancing long-term care expenditures. The grant provides enhanced match for HCBS provided during the first 365 days of community living following transition.



Plan of Care – As it pertains to Population Health the plan of care is a personalized plan to meet a member’s specific needs and contains the following elements: prioritized goals that consider member and care giver needs which are documented; a time frame for re-evaluation; the resources to be utilized; a plan for continuity of care, including transition of care and transfers; and uses a collaborative approach including family participation. The plan of care is built upon the information collected from the health assessment to actively engage the member in developing goals and identifying a course of action to respond to the members’ needs. The goals and actions in the plan of care must address medical, social, educational, and other services needed by the member. Providing educational materials alone does not meet the intent of this factor.

As it pertains to CHOICES, the plan of care is a written plan developed by the CONTRACTOR in accordance with Section 2.9. 6.6 through a person-centered planning process that assesses the member’s needs and outlines the services and supports that will be provided to the member to meet their identified needs (including unpaid supports provided by family members and other caregivers, and paid services provided by the CONTRACTOR and other payor sources) and addresses the member’s health and long-term services and support needs in a manner that reflects member preferences and goals. The person-centered planning process is directed by the member with long-term support needs, and may include a representative whom the member has freely chosen and others chosen by the member to contribute to the process. This planning process, and the resulting person-centered plan of care, will assist the member in achieving personally defined outcomes in the most integrated community setting, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health and welfare.

Transition Team – Teams the CONTRACTOR shall maintain beginning July 1, 2015 to fulfill its obligations pursuant to Nursing Facility to Community Transitions (see Section 2.9.6.8) and the MFP Rebalancing Demonstration (see Section 2.9.8). The Transition Team shall consist of at least one (1) dedicated staff person without a caseload in each Grand Region in which the CONTRACTOR serves TennCare members, who also meets the qualifications of a care coordinator specified in Section 2.9.6.11. The transition team may also include other persons with relevant expertise and experience who are assigned to support the care coordinator(s) in the performance of transition activities for a CHOICES Group 1 member. Any such staff shall not be reported in the care coordinator ratios specified in Section 2.9.6.11, and shall be responsible for proactively identifying TennCare members in NFs who are candidates to transition to the community and to further assist with the completion of the transition process specified in Section 2.9.6.8. All transition activities identified as responsibilities of the care coordinator shall be completed by an individual who meets all of the requirements to be a care coordinator.

2. Section 2.4.4 shall be amended by adding a new Section 2.4.4.6 as follows:

2.4.4.6 Persons with Suspended Eligibility

Pursuant to TCA 71-5-106(r), TENNCARE shall suspend TennCare eligibility status for persons who are incarcerated in a public institution. A suspended individual shall be eligible to receive medical assistance for care received outside of a jail or correctional facility in a hospital or other health care facility if the stay is for more than twenty-four (24) hours. A suspended individual shall not be eligible for TennCare services described in Section 2.6 of this Contract except as described above.

3. The fourth paragraph in the “Benefit Limit” Column of the “Non-emergency Medical Transportation (including Non-Emergency Ambulance Transportation)” Service in Section 2.6.1.3 shall be deleted and replaced as follows:

Mileage reimbursement, car rental fees, or other reimbursement for use of a private automobile (as defined in Exhibit A to Attachment XI) is not a covered NEMT service, unless otherwise allowed or required by TENNCARE as a pilot project or a cost effective alternative service.



4. **Community-based residential alternatives in Section 2.6.1.5.3 shall be amended by adding language to the Group 3 column and a corresponding footnote as follows:**

2.6.1.5.3 The following long-term care services are available to CHOICES members, per Group, when the services have been determined medically necessary by the CONTRACTOR.

Service and Benefit Limit	Group 1	Group 2	Group 3
Nursing facility care	X	Short-term only (up to 90 days)	Short-term only (up to 90 days)
Community-based residential alternatives		X	(Specified CBRA services and levels of reimbursement only. See below) ¹
Personal care visits (up to 2 visits per day at intervals of no less than 4 hours between visits)		X	X
Attendant care (up to 1080 hours per calendar year; up to 1400 hours per full calendar year only for persons who require covered assistance with household chores or errands in addition to hands-on assistance with self-care tasks)		X	X
Home-delivered meals (up to 1 meal per day)		X	X
Personal Emergency Response Systems (PERS)		X	X
Adult day care (up to 2080 hours per calendar year)		X	X
In-home respite care (up to 216 hours per calendar year)		X	X
In-patient respite care (up to 9 days per calendar year)		X	X
Assistive technology (up to \$900 per calendar year)		X	X

¹ CBRA for which Group 3 members are eligible include only: Assisted Care Living Facility services, Community Living Supports 1 (CLS1), and Community Living Supports-Family Model 1 (CLS-FM1)



Service and Benefit Limit	Group 1	Group 2	Group 3
Minor home modifications (up to \$6,000 per project; \$10,000 per calendar year; and \$20,000 per lifetime)		X	X
Pest control (up to 9 units per calendar year)		X	X

5. **Section 2.6.7.2.3.1 and 2.6.7.2.3.2 shall be deleted and replaced as follows:**

2.6.7.2.3.1 The Contractor shall delegate collection of patient liability for CHOICES Group 2 and 3 members who reside in a CBRA (i.e., an assisted care living facility, community living support, community living support-family model, or adult care home as licensed under 68-11-201) to the CBRA and shall pay the facility net of the applicable patient liability amount.

2.6.7.2.3.2 The CONTRACTOR shall collect patient liability from CHOICES Group 2 and Group 3 members (as applicable) who receive CHOICES HCBS in his/her own home, including members who are receiving short-term nursing facility care, or who receive adult day care services and from Group 2 members who receive Companion Care.

6. **Section 2.8.2.1.1 shall be deleted and replaced as follows:**

2.8.2.1.1 The CONTRACTOR shall make reasonable attempts to assess member’s health risk utilizing the appropriate common mini-health survey approved by the Bureau and Population Health staff or a comprehensive health risk assessment. The information collected from these health surveys will be used to align individual members with appropriate intervention approaches and maximize the impact of the services provided.

7. **Section 2.8.3.1 shall be deleted and replaced as follows:**

2.8.3.1 At time of enrollment and annually thereafter, the CONTRACTOR shall make a reasonable attempt to assess the member’s health as detailed in Section 2.8.2.1.1 of this contract. A completed approved mini-health survey or comprehensive health risk assessment done in the prior twelve (12) months by any TennCare MCO may be used to meet the annual requirement.

8. **Section 2.8.4.5.2 shall be deleted and replaced as follows:**

2.8.4.5.2 The CONTRACTOR shall at a minimum make three outreach attempts to contact each newly identified member as eligible for Chronic Care Management to offer the member enrollment in the program. For those members known to have urgent or critical needs more and varied types of contact attempts may be indicated. All non-critical eligible members must have three outreach attempts within three months of their identification. For those members where contact failed but appear on the next refreshed list the CONTRACTOR is not obligated to attempt another contact for one hundred and eighty (180) days.



9. **Section 2.8.4.7.2 shall be deleted and replaced as follows:**

2.8.4.7.2 The CONTRACTOR shall at a minimum make three (3) outreach attempts as detailed in Section 2.8.4.5.2 of this Contract to contact newly identified members eligible for Complex Care Management to offer the member enrollment in the program. The outreach attempts shall be completed within the appropriate timeframes according to NCQA standard QI 7 for complex case management. For those members known to have urgent or critical needs, more and varied types of contact attempts may be indicated. For those members where contact failed but appear on the next refreshed list, the CONTRACTOR is not obligated to attempt another contact for one hundred and eighty (180) days.

10. **Section 2.8.7 shall be deleted and replaced as follows:**

2.8.7 **Clinical Practice Guidelines**

Population Health programs shall utilize evidence-based clinical practice guidelines that follow current NCQA QI 9 guidelines. A list of clinical practice guidelines for conditions referenced in Section 2.8.2.1.3.1 of this Contract, as well as Maternity, Obesity, and Preventive Services must be submitted for review by TENNCARE on an annual basis.

11. **Section 2.9.2.1.4.2 shall be deleted and replaced as follows:**

2.9.2.1.4.2. For a member in CHOICES Group 2 or 3, within thirty (30) days of notice of the member's enrollment with the CONTRACTOR, a care coordinator shall conduct a face-to-face visit (see Section 2.9.6.2.5), including a comprehensive needs assessment (see Section 2.9.6.5) and a caregiver assessment, and develop a plan of care (see Section 2.9.6.6), and the CONTRACTOR shall authorize and initiate CHOICES HCBS in accordance with the new plan of care (see Section 2.9.6.2.5). If a member in Group 2 or 3 is receiving short-term nursing facility care on the date of enrollment with the CONTRACTOR, a care coordinator shall complete a face-to-face visit prior to the expiration date of the level of nursing facility services approved by TENNCARE, but no later than thirty (30) days after enrollment to determine appropriate needs assessment and care planning activities (see Section 2.9.6.2.5 for members who will be discharged from the nursing facility and remain in Group 2 or 3 and Section 2.9.6.2.4 for members who will remain in the nursing facility and be enrolled in Group 1). If the expiration date for the level of nursing facility services approved by TENNCARE occurs prior to thirty (30) days after enrollment, and the CONTRACTOR is unable to conduct the face-to-face visit prior to the expiration date, the CONTRACTOR shall be responsible for facilitating discharge to the community or enrollment in Group 1, whichever is appropriate prior to the member's exhaustion of the 90-day short-term NF benefit.

12. **Section 2.9.3.2 shall be amended by adding additional text to the end of the existing paragraph as follows:**

2.9.3.2 For each transitioning CHOICES member, the CONTRACTOR shall be responsible for the costs of continuing to provide covered long-term care services authorized by the member's previous MCO, including, as applicable, CHOICES HCBS in the member's approved plan of care and nursing facility services without regard to whether such services are being provided by contract or non-contract providers for at least thirty (30) days, which shall be extended as necessary to ensure continuity of care pending the provider's contracting with the



CONTRACTOR or the member's transition to a contract provider; if the member is transitioned to a contract provider, the CONTRACTOR shall facilitate seamless transition to the new provider.

13. **Section 2.9 shall be amended by adding a new Section 2.9.4 as follows and Section 2.9.5 currently labeled "Left Blank Intentionally" shall be amended to delete "Left Blank Intentionally" and replaced with the existing Section 2.9.4 and pick up with the following Sections being numbered accordingly.**

2.9.4 **CHOICES Assessments for a CONTRACTOR'S Current Members Under the Age of Twenty-One**

2.9.4.1 When a member, other than those receiving home health or private duty nursing services in excess of specified benefit limits for adults is turning age twenty-one (21), the CONTRACTOR shall, at least sixty (60) days prior to the member's 21st birthday, conduct an in-home assessment to determine whether the member is interested in applying for CHOICES, and if so, shall, pursuant to Section 2.9.6.3.8 conduct an in-home assessment and, subject to the member's eligibility to enroll in CHOICES, coordinate with TENNCARE to help facilitate enrollment in CHOICES and initiation of CHOICES benefits on the member's 21st birthday.

14. **Section 2.9.6.2.5.3 shall be amended by adding the phrase "conduct a caregiver assessment," as follows:**

2.9.6.2.5.3 The care coordinator shall, for all other CHOICES members in Groups 2 and 3 not specified in Sections 2.9.6.2.5.1 –2.9.6.2.5.2 above, within ten (10) business days of notice of the member's enrollment in CHOICES, conduct a face-to-face visit with the member, perform a comprehensive needs assessment (see Section 2.9.6.5), conduct a caregiver assessment, develop a plan of care (see Section 2.9.6.6), and authorize and initiate CHOICES HCBS.

15. **Section 2.9.6.2.5.9.2 shall be deleted and replaced as follows:**

2.9.6.2.5.9.2 If the Care Coordinator determines that the member's needs cannot be safely met in the community within the array of services and supports that would be available as described in Section 2.9.6.2.5.9 the Care Coordinator shall, in a manner prescribed by TENNCARE, complete a *Safety Determination Request Form*, including all required documentation as required by TENNCARE, and coordinate with TENNCARE to review the member's level of care, and if nursing facility level of care is approved, to facilitate transition to CHOICES Group 1 or 2.



Amendment 36 (cont.)

16. **Section 2.9.6.2.5 shall be amended by adding new Sections 2.9.6.2.5.16 through 2.9.6.2.5.16.1.4 as follows:**

2.9.6.2.5.16 Caregiver Assessment

2.9.6.2.5.16.1 *For members in Groups 2 and 3*

2.9.6.2.5.16.1.1 The care coordinator shall conduct a caregiver assessment using a tool prior approved by TENNCARE and in accordance with protocols specified by TENNCARE as part of its face-to-face visit with new members in CHOICES Groups 2 and 3 (see Section 2.9.6.2.5) and as part of its face-to-face intake visit for current members applying for CHOICES Groups 2 and 3.

2.9.6.2.5.16.1.2 At a minimum, for members in CHOICES Groups 2 and 3, the caregiver assessment shall include: (1) an overall assessment of the family member(s) and/or caregiver(s) providing services to the member to determine the willingness and ability of the family member(s) or caregiver(s) to contribute effectively to the needs of the member, including employment status and schedule, and other care-giving responsibilities (2) an assessment of the caregiver's own health and well-being, including medical, behavioral, or physical limitations as it relates to the caregiver's ability to support the member; (3) an assessment of the caregiver's level of stress related to care-giving responsibilities and any feelings of being overwhelmed; (4) identification of the caregiver's needs for training in knowledge and skills in assisting the person needing care; and (5) identification of any service and support needs to be better prepared for their care-giving role.

2.9.6.2.5.16.1.3 The caregiver assessment shall be conducted at least once every 365 days as part of the annual review, upon a significant change in circumstances as defined in Section 2.9.6.9.2.1.17, and as the care coordinator deems necessary.

2.9.6.2.5.16.1.4 All requirements pertaining to caregiver assessments shall be effective on July 1, 2015.

17. **The renumbered Section 2.9.6.3.1 shall be amended by adding a new Section 2.9.6.3.1.3 as follows and renumbering the remaining Section accordingly, including any references thereto.**

2.9.6.3.1.3 Identification by the CONTRACTOR of a member receiving home health or private duty nursing services who will be subject to a reduction in covered services provided by the CONTRACTOR upon turning twenty-one (21) years of age (see Section 2.9.4);

18. **Section 2.9.6.3.14 shall be deleted and replaced with Sections 2.9.6.3.14 through 2.9.6.3.14.6 as follows:**

2.9.6.3.14 Once completed, in the manner prescribed by TENNCARE the CONTRACTOR shall submit the level of care (i.e., PAE application) and, for members requesting CHOICES HCBS, supporting documentation, as specified by TENNCARE, to verify that the member's needs can be safely and effectively met in the community and within the cost neutrality cap or expenditure cap, as applicable, to TENNCARE as soon as possible but no later than five (5) business days of the face-to-face visit.



Amendment 36 (cont.)

- 2.9.6.3.14.1 If the Contractor determines that the member's assessed acuity score is less than nine (9) and the member's needs cannot be safely met in the community within the array of services and supports available if the member were enrolled in Group 3, or the member or his or her representative request a safety determination, the Contractor shall, in accordance with timeframes specified in 2.9.6.3.14 and in a manner specified in TennCare protocol, complete the *Safety Determination Request Form*, including all required documentation, and submit the completed *Safety Determination Request Form* to TENNCARE along with the member's completed PAE.
- 2.9.6.3.14.2 If the CONTRACTOR is unable to obtain the supporting documentation within five (5) business days, such as required medical information, and the absence of such documentation delays the submission of the PAE to TENNCARE, the CONTRACTOR must document and continue efforts to collect supporting documentation. Such efforts may include assisting member to secure physician visit, and or other medical appointments necessary in order to obtain required supporting documentation.
- 2.9.6.3.14.3 Efforts to collect supporting documentation required for the submission of the PAE shall include at least three (3) attempts utilizing the following methods or combination of methods: contacting the physician, medical facility, or other healthcare entity by telephone, fax and/or in writing; visiting the healthcare entity, if possible and practicable, to request and/or pick up the required documentation; and contacting the member by phone, face-to-face, or in writing to request assistance in obtaining the needed documentation. Multiple faxes or calls to the physician or provider shall not be sufficient. If a recent history and physical or other medical records supporting the functional deficits are not available (e.g., the applicant has not received medical care in the last 365 days), the CONTRACTOR shall help to arrange an appointment with the member's primary care provider in order to obtain the needed information.
- 2.9.6.3.14.4 The CONTRACTOR must submit the PAE to TENNCARE within twenty (20) business days from the date of the face-to-face visit, regardless of whether the CONTRACTOR has received the supporting documentation. After submitting the PAE to TENNCARE, if the PAE submission results in a denial, the CONTRACTOR shall continue diligent efforts to collect supporting documentation as specified in Section 2.9.6.3.14.2. Pursuant to TennCare Rules, if within thirty (30) calendar days of the initial PAE denial, the CONTRACTOR obtains additional supporting documentation, the CONTRACTOR shall submit a revised PAE with the supporting documentation. After thirty (30) calendar days from the initial PAE denial have passed, the CONTRACTOR shall have no obligation to make efforts to collect supporting documentation, but shall be required to submit a new PAE with supporting documentation to TENNCARE if such documentation is subsequently received.
- 2.9.6.3.14.5 The CONTRACTOR shall be responsible for ensuring that the level of care, including Safety Determination Request Form, as applicable, is accurate and complete, satisfies all technical requirements specified by TENNCARE, and accurately reflects the member's current medical and functional status based on information gathered, at a minimum, from the member, his or her representative, the Care Coordinator's direct observations, and the history and physical or other medical records which shall be submitted with the application. The CONTRACTOR shall note in the level of care any discrepancies between these sources of information, and shall provide explanation regarding how the CONTRACTOR addressed such discrepancies in the level of care.



Amendment 36 (cont.)

2.9.6.3.14.6 If TENNCARE receives a safety request from a NF or hospital on behalf of one of the CONTRACTOR's members, and the request contains insufficient medical evidence for TENNCARE to make a safety determination, TENNCARE may request that the CONTRACTOR conduct an assessment pursuant to TennCare Rules to gather additional information needed by TENNCARE to make a safety determination. If TENNCARE makes such a request, the CONTRACTOR shall conduct the assessments required pursuant to TennCare Rules and complete the Safety Determination Request Form, including all required documentation, within five (5) business days from notification by TENNCARE, except when a delay results from the needs or request of the member which shall be documented in writing.

19. **Section 2.9.6.3.20.3 shall be amended as follows:**

2.9.6.3.20.3 Except as required pursuant to Section 2.14.5.8, the CONTRACTOR may decide whether it will issue service authorizations for nursing facility services, or whether it will instead process claims for such services in accordance with the level of care and/or reimbursement (including the duration of such level of care and/or reimbursement) approved by TENNCARE (see Section 2.14.1.15). The CONTRACTOR may however reimburse a facility at the Level I per diem rate when such rate is billed by the facility and there is an approved LOC eligibility segment for such level of reimbursement. If the CONTRACTOR elects to authorize nursing facility services, the CONTRACTOR may determine the duration of time for which nursing facility services will be authorized. However, the CONTRACTOR shall be responsible for monitoring its authorizations and for ensuring that there are no gaps in authorizations for CHOICES nursing facility services in accordance with the level of care and/or reimbursement approved by TENNCARE. Retroactive entry or adjustments in service authorizations for nursing facility services should be made only upon notification of retroactive enrollment into or disenrollment from CHOICES Group 1a or 1b via the outbound 834 file from TENNCARE.

20. **Section 2.9.6.4.4 shall be amended by adding the words "caregiver assessment" as follows:**

2.9.6.4.4 The CONTRACTOR may utilize a care coordination team approach to performing care coordination activities prescribed in Section 2.9.6. For each CHOICES member, the CONTRACTOR's care coordination team shall consist of the member's care coordinator and specific other persons with relevant expertise and experience appropriate to address the needs of CHOICES members. Care coordination teams shall be discrete entities within the CONTRACTOR's organizational structure dedicated to fulfilling CHOICES care coordination functions. The CONTRACTOR shall establish policies and procedures that specify, at a minimum: the composition of care coordination teams; the tasks that shall be performed directly by the care coordinator as specified in this Contract, including needs assessment, caregiver assessment, development of the plan of care, and all minimum care coordination contacts; the tasks that may be performed by the care coordinator or the care coordination team; measures taken to ensure that the care coordinator remains the member's primary point of contact for the CHOICES program and related issues; escalation procedures to elevate issues to the care coordinator in a timely manner; and measures taken to ensure that if a member needs to reach his/her care coordinator specifically, calls that require immediate attention by a care coordinator are handled by a care coordinator and calls that do not require immediate attention are



returned by the member's care coordinator the next business day. The CONTRACTOR may elect to utilize specialized intake coordinators or intake teams for initial needs assessment and care planning activities. All intake activities identified as responsibilities of the care coordinator shall be completed by an individual who meets all of the requirements to be a care coordinator. Should the CONTRACTOR elect to utilize specialized intake coordinators or intake teams, the CONTRACTOR shall develop policies and procedures which specify how the contractor will coordinate a seamless transfer of information from the intake coordinator or team to the member's care coordinator.

21. **Section 2.9.6.6.2.4 shall be deleted and replaced as follows:**

2.9.6.6.2.4 The plan of care developed for CHOICES members in Groups 2 and 3 prior to initiation of CHOICES HCBS shall at a minimum include: (1) pertinent demographic information regarding the member including the member's current address and phone number(s), the name and contact information of any representative and a list of other persons authorized by the member to have access to health care (including long-term care) related information and to assist with assessment, planning, and/or implementation of health care (including long-term care) related services and supports; (2) care, including specific tasks and functions, that will be performed by family members and other caregivers; (3) caregiver training or supports identified through the caregiver assessment that are needed to support and sustain the caregiver's ability to provide care for the member; (4) home health, private duty nursing, and long-term care services the member will receive from other payor sources including the payor of such services; (5) home health and private duty nursing that will be authorized by the CONTRACTOR; (6) CHOICES HCBS that will be authorized by the CONTRACTOR, including the amount, frequency, duration, and scope (tasks and functions to be performed) of each service to be provided, the schedule at which such care is needed, and the address or phone number(s) that will be used to log visits into the EVV system, as applicable; (7) a detailed back-up plan for situations when regularly scheduled HCBS providers are unavailable or do not arrive as scheduled; the back-up plan may include paid and unpaid supports and shall include the names and telephone numbers of persons and agencies to contact and the services provided by listed contacts; the CONTRACTOR shall assess the adequacy of the back-up plan; and (8) for CHOICES Group 2 members, the projected TennCare monthly and annual cost of home health and private duty nursing identified in (5) above, and the projected monthly and annual cost of CHOICES HCBS specified in (6) above, and for CHOICES Group 3 members, the projected total cost of CHOICES HCBS specified in (6) above, excluding the cost of minor home modifications.

22. **Section 2.9.6.6.2.6 shall be deleted and replaced as follows:**

2.9.6.6.2.6 The member's care coordinator/care coordination team shall ensure that the member or his/her representative, as applicable, reviews, signs and dates the plan of care as well as any substantive updates, including but not limited to any changes in the amount, duration or type of HCBS that will be provided. The care coordinator shall also sign and date the plan of care, along with any substantive updates. The plan of care shall be updated and signed by the member or his/her representative, as applicable, and the care coordinator annually and any time the member experiences a significant change in needs or circumstances (see Section 2.9.6.9.2.1.17).



23. Section 2.9.6.8.25 shall be deleted and replaced as follows:

2.9.6.8.25 To facilitate nursing facility to community transition, the CONTRACTOR shall, effective July 1, 2015, maintain at least one (1) dedicated staff person without a caseload who meets the qualifications of a care coordinator specified in Section 2.9.6.11, in each Grand Region in which the CONTRACTOR serves TennCare members. The dedicated staff person(s) shall not be reported in the care coordinator ratios specified in Section 2.9.6.11. Such staff person(s) shall be responsible for proactively identifying TennCare members in NFs who are candidates to transition to the community, and to further assist with the completion of the transition process specified in Section 2.9.6.8. All transition activities identified as responsibilities of the care coordinator shall be completed by an individual who meets all of the requirements to be a care coordinator.

24. Section 2.9.6.9.2.1.15 shall be amended by adding language to the end of the Section as follows:

2.9.6.9.2.1.15 Notify TENNCARE immediately, in the manner specified by TENNCARE, if the CONTRACTOR determines that the needs of a member in CHOICES Group 2 cannot be met safely in the community and within the member's cost neutrality cap or that the needs of a member in CHOICES Group 3 cannot be met safely in the community and within the member's expenditure cap;

25. Section 2.9.6.9.3.1 shall be amended by deleting the word "annually" and replacing it with the phrase "once every 365 days" as follows:

2.9.6.9.3.1.1 In the manner prescribed by TENNCARE, conduct a level of care reassessment at least once every 365 days and within five (5) business days of the CONTRACTOR's becoming aware that the member's functional or medical status has changed in a way that may affect level of care eligibility.

26. Sections 2.9.6.9.3.1.1.1 and 2.9.6.9.3.1.1.2 shall be deleted and replaced as follows:

2.9.6.9.3.1.1.1 If the level of care assessment indicates a change in the level of care, or if the assessment was prompted by a request by a member, a member's representative or caregiver or another entity for a change in level of services, the level of care shall be forwarded to TENNCARE within five (5) business days of the reassessment for determination;

2.9.6.9.3.1.1.2 Except as specified in Section 2.9.6.9.3.1.1.1, if the level of care assessment indicates no change in level of care, the CONTRACTOR shall document the date the level of care assessment completed in the member's file; any level of care assessments prompted by a request for a change in level of services shall be submitted to TENNCARE for determination.



27. **Section 2.9.6.9.3.1.1.3.2 shall be deleted and replaced as follows:**

2.9.6.9.3.1.1.3.2 The CONTRACTOR shall also, for purposes of complying with the Terms and Conditions of the State’s Waiver, assess once every 365 days the member’s LOC eligibility based on the new LOC criteria in place as of July 1, 2012. The CONTRACTOR shall report in the manner prescribed by TENNCARE the results of the LOC reassessment within ten (10) calendar days of the LOC reassessment completion. This information will be used by the State in its expenditure reporting to CMS.

28. **Sections 2.9.6.11.3 through 2.9.6.11.5 shall be deleted and replaced as follows:**

2.9.6.11.3 The CONTRACTOR shall ensure that an adequate number of care coordinators are available and to ensure the required staffing ratios (see Sections 2.9.6.11.4, 2.9.6.11.5 and 2.9.6.11.6.3 through 2.9.6.11.6.5) are maintained to address the needs of CHOICES members and meet all the requirements described in this Contract.

2.9.6.11.4 The required average weighted care coordinator-to-CHOICES member staffing ratio is no more than 1:125. Effective July 1, 2015, the required average weighted care coordinator-to-CHOICES member staffing ratio shall be no more than 1: 115. Such average shall be derived by dividing the total number of full-time equivalent care coordinators by the total weighted value of CHOICES members as delineated below.

2.9.6.11.5 The required maximum caseload for any individual care coordinator is a weighted value of no more than one hundred seventy-five (175) CHOICES members. Effective July 1, 2015, the required maximum caseload for any individual care coordinator is a weighted value of no more than one hundred sixty-five (165) CHOICES members.

29. **Section 2.9.6.11.6.3 through 2.9.6.11.6.5 shall be deleted and replaced as follows:**

2.9.6.11.6.3 Each CHOICES Group 3 member shall be factored into the weighted caseload and staffing ratio calculations utilizing an acuity level of one and three quarters (1.75). Effective July 1, 2015, each CHOICES Group 3 member shall be factored into the weighted caseload and staffing ratio calculations utilizing an acuity level of two (2):

2.9.6.11.6.4 Using the delineated acuity factors, the following provides examples of the composition of caseloads with a weighted value of 125(Effective through June 30, 2015):

CHOICES Group 1	CHOICES Group 2	CHOICES Group 3	Total CHOICES Members on Caseload
125	0		125
100	10		110
50	9	30	89
25	26	20	71
0	50		50

2.9.6.11.6.4.1 Effective July 1, 2015, using the delineated acuity factors, the following provides examples of the composition of caseloads with a weighted value of 115:



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CHOICES Group 1	CHOICES Group 2	CHOICES Group 3	Total CHOICES Members on Caseload
115	0		115
100	6		106
50	10	20	80
25	24	15	64
0	46		46

2.9.6.11.6.5 Using the delineated acuity factors, the following delineates the composition of caseloads with a weighted value of 175(Effective through June 30, 2015):

CHOICES Group 1	CHOICES Group 2	CHOICES Group 3	Total CHOICES Members on Caseload
175	0		175
125	10		110
75	19	30	124
50	36	20	106
0	70		70

2.9.6.11.6.5.1 Effective July 1, 2015, using the delineated acuity factors, the following delineates the composition of caseloads with a weighted value of 165:

CHOICES Group 1	CHOICES Group 2	CHOICES Group 3	Total CHOICES Members on Caseload
165	0		165
125	16		141
75	20	20	115
50	34	15	99
0	66		66

30. **Sections 2.9.6.11.9 and 2.9.6.11.10 shall be deleted and replaced as follows:**

2.9.6.11.9 In the event that the CONTRACTOR is determined to be deficient with any requirement pertaining to care coordination as set forth in this Contract, the amount of financial sanctions assessed shall take into account whether or not the CONTRACTOR has complied with the required average weighted care coordinator to CHOICES member staffing ratio and the maximum weighted care coordinator caseload amounts set forth in Sections 2.9.6.11.4 and 2.9.6.11.5, based on the most recent monthly CHOICES Caseload and Staffing Ratio Report (see Section 2.30.6.7). All applicable sanctions set forth in Sections 5.20.2.2.6., 5.20.2.2.7.A.16, 5.20.2.2.7.A.18, 5.20.2.2.7.A.19, 5.20.2.2.7.A.20, 5.20.2.2.7.A.21, 5.20.2.2.7.A.22, 5.20.2.2.7.A.23, 5.20.2.2.7.A.28, 5.20.2.2.7.A.29, 5.20.2.2.7.A.30, 5.20.2.2.7.A.31, 5.20.2.2.7.A.32, 5.20.2.2.7.A.33, 5.20.2.2.7.A.34, 5.20.2.2.7.A.35, 5.20.2.2.7.A.37, 5.20.2.2.7.B.21, and 5.20.2.2.7.C.7 of this Contract shall be multiplied by two (2) when the CONTRACTOR has not complied with these requirements.



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2.9.6.11.10 TennCare will reevaluate Care Coordinator-to-CHOICES member staffing ratio requirements on at least an annual basis and may make adjustments based on the needs of CHOICES members, CHOICES program requirements and MCO performance.

31. **Section 2.9.6.11.18.15 shall be deleted and replaced as follows:**

2.9.6.11.18.15 Management of transfers between nursing facilities and CBRA, including adult care homes, community living supports, and community living supports-family model;

32. **Section 2.9.7.4.3.4 shall be deleted and replaced as follows:**

2.9.7.4.3.4 If eligible CHOICES HCBS are not initiated within sixty (60) days following referral to the FEA, the CONTRACTOR shall notify the member that eligible CHOICES HCBS must be initiated by contract providers unless these HCBS are not needed on an ongoing basis in order to safely meet the member's needs in the community, in which case, the CONTRACTOR shall submit documentation to TENNCARE to begin the process of disenrollment from CHOICES. Even if services are initiated by contract providers, if consumer directed services are not initiated within ninety (90) days of FEA referral, the CONTRACTOR shall assess whether consumer direction is appropriate for the member at this time or whether the member should be disenrolled from consumer direction. Disenrollment from consumer direction does not preclude the member from initiating consumer directed services at a later point.

33. **Section 2.9.8.2.3 shall be amended by deleting the reference to "nursing facility" and replacing it with the reference to "Qualified Institution" as follows:**

2.9.8.2.3 Members may only elect to participate in MFP and the CONTRACTOR may only enroll a member into MFP prior to the member's transition from the Qualified Institution to the community. Members will not be eligible to enroll in MFP if they have already transitioned out of the Qualified Institution.

34. **Section 2.9.8.3.5 shall be deleted and replaced as follows:**

2.9.8.3.5 The member's care coordinator or transition team shall, using information provided by TENNCARE, provide each potential MFP participant with an overview of MFP and answer any questions the participant has. The CONTRACTOR shall have each potential MFP participant or his authorized representative, as applicable, sign an MFP Informed Consent Form affirming that such overview has been provided by the CONTRACTOR and documenting the member's decision regarding MFP participation.

35. **Paragraphs 2.9.14.2, 2.9.14.2.1 and 2.9.14.2.4 shall be deleted and replaced as follows:**

2.9.14.2 The CONTRACTOR shall coordinate with a FBDE member's D-SNP regarding discharge planning from any inpatient setting or observation stay when Medicaid LTSS (NF or HCBS), Medicaid home health or private duty nursing, or other Medicaid services may be needed upon discharge in order to ensure that care is provided in the most appropriate, cost effective and integrated setting.

2.9.14.2.1 The CONTRACTOR shall develop, for review and approval by TENNCARE, policies, procedures and training for CONTRACTOR staff, including Care Coordinators, regarding



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coordination with a FBDE member's D-SNP in discharge planning from an inpatient setting or observation stay to the most appropriate, cost effective and integrated setting.

2.9.14.2.4 The CONTRACTOR shall establish processes to ensure that all required notifications from the member's D-SNP to the CONTRACTOR of inpatient admission, including planned and unplanned admissions to the hospital or a SNF, as well as all required notifications of observation days and any reported emergency room visits, are timely and appropriately triaged.

36. Section 2.11.6.1 shall be deleted and replaced as follows:

2.11.6.1 The CONTRACTOR shall, pursuant to TCA 71-5-1412 contract with any licensed and certified nursing facility willing to contract with the MCO to provide that service under the same terms and conditions as are offered to any other participating facility contracted to provide that service under any policy, contract or plan that is part of the TennCare managed long-term care service delivery system. Terms and conditions shall not include the rate of reimbursement. This does not prevent the CONTRACTOR from enforcing the provisions of its contract with the facility. This section shall expire on June 30, 2017. Thereafter, the CONTRACTOR shall contract with a sufficient number of nursing facilities in order to have adequate capacity to meet the needs of CHOICES members for nursing facility services.

37. Section 2.11.6.6.6 shall be deleted and replaced as follows:

2.11.6.6.6 Demonstration of the CONTRACTOR's efforts to develop and enhance existing community-based residential alternatives (including adult care homes, community living supports, and community living supports-family model) capacity for elders and/or adults with physical disabilities. The CONTRACTOR shall specify related activities, including provider recruitment activities, and provide a status update on capacity building.

38. Section 2.11.6 shall be amended by adding a new Section 2.11.6.7 as follows and renumbering the remaining Section accordingly, including any references thereto.

2.11.6.7 The CONTRACTOR, in collaboration with TENNCARE, shall develop a strategy to strengthen networks with housing providers and develop access to affordable housing. The CONTRACTOR shall actively participate with TENNCARE, other TennCare managed care contractors, and other stakeholders to develop and implement strategies for the identification of resources to assist in transitioning CHOICES members to affordable housing. To demonstrate this strategy, the CONTRACTOR shall report annually to TENNCARE on the status of any affordable housing development and networking strategies it elects to implement (See Section 2.30.6.13).



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39. **Section 2.11 shall be amended by adding new Section 2.11.7 through 2.11.7.1 as follows and renumbering the remaining Section accordingly, including any references thereto.**

2.11.7 Special Conditions for Persons with Intellectual or Developmental Disabilities (I/DD)

2.11.7.1 Members in TennCare Select, who have an intellectual or developmental disability but are not enrolled in SelectCommunity, shall have access to the provider networks in the Integrated Health Services Delivery Model (See Section 3A).

40. **Section 2.11.8.4. shall be amended by adding a new Section 2.11.8.4.1.6 which shall read as follows:**

2.11.8.4.1.6 The CONTRACTOR shall be responsible for tracking and obtaining copies of current licensure and/or certification (as applicable) for all of the CONTRACTOR's CHOICES HCBS providers. The CONTRACTOR shall be required to present this current licensure and/or certification to TENNCARE upon request. The CONTRACTOR shall further require all of the CONTRACTOR's CHOICES HCBS providers to submit copies of current licensure and/or certification (as applicable) to the CONTRACTOR.

41. **Paragraph 2.12.9.66.1 shall be deleted and replaced as follows:**

2.12.9.66.1 Language that no person on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin, or any other classifications protected under federal or state laws shall be excluded from participation in, except as specified in Section 2.3.5, or be denied benefits of, or be otherwise subjected to discrimination in the performance of provider's obligation under its agreement with the CONTRACTOR or in the employment practices of the provider. The provider shall upon request show proof of such nondiscrimination compliance and shall post notices of nondiscrimination in conspicuous places available to all employees, TennCare applicants, and enrollees.

42. **Section 2.12.10 shall be amended by adding new Sections 2.12.10.8, 2.12.10.15, and 2.12.10.16, and renumbering the remaining Section accordingly, including any references thereto.**

2.12.10.8 Require the nursing facility to submit complete and accurate PAEs that satisfy all technical requirements specified by TENNCARE, and accurately reflect the member's current medical and functional status, including Safety Determination Requests. The nursing facility shall also submit all supporting documentation required in the PAE and *Safety Determination Request Form*, as applicable and required pursuant to TennCare Rules.

2.12.10.15 Require that nursing facilities specify whether the provider will be contracted to provide SNF services at an ERC rate for Ventilator Weaning, Chronic Ventilator Care, and/or Tracheal Suctioning in addition to standard NF and SNF services (each level of ERC reimbursement must be uniquely identified).

2.12.10.16 Prior to entering into an agreement with a NF for SNF services at an enhanced rate for ventilator weaning, chronic ventilator care, and/or tracheal suctioning, the CONTRACTOR shall verify that the NF has been licensed by the Tennessee Department of Health to provide such specialized ERC, is certified by CMS for program participation, and is compliant with



threshold standards of care for the applicable type of ERC and requirements for ERC reimbursement established by TENNCARE.

43. **Section 2.12.11 shall be amended by adding new section 2.12.11.14 which shall read as follows:**

2.12.11.14 The CONTRACTOR shall require all of the CONTRACTOR's CHOICES HCBS providers to submit copies of current licensure and/or certification (as applicable) to the CONTRACTOR.

44. **Section 2.13 shall be amended by adding a new Section 2.13.26 as follows:**

2.13.26 Claims for Persons with Suspended Eligibility

The CONTRACTOR agrees to pay claims in accordance with the CONTRACTOR's current policies and procedures (including but not limited to medical necessity and utilization guidelines) to a provider on behalf of persons with suspended eligibility that meet the criteria specified in Section 2.4.4.6 of this Contract on and as needed basis when billed by the provider. The CONTRACTOR shall pay the provider the negotiated rate or in the case of an out of network provider, the CONTRACTOR shall negotiate provider reimbursement subject to TENNCARE's prior written approval.

45. **Section 2.14.1.3 shall be deleted in its entirety and the remaining Sections in 2.14.1 shall be renumbered accordingly, including any references thereto.**

46. **The renumbered 2.14.1.15.1 shall be deleted and replaced as follows:**

2.14.1.15.1 Review ED utilization data, at a minimum, every six (6) months to identify members with utilization exceeding the threshold defined by TENNCARE as ten (10) or more visits in the defined six (6) month period (January through June and July through December);

47. **Section 2.14.5 shall be amended by adding new Sections 2.14.5.7 and 2.14.5.8 which shall read as follows:**

2.14.5.7 The CONTRACTOR shall determine medical necessity of ventilator weaning and short term tracheal suctioning for individuals recently weaned from a ventilator, but who still require intensive respiratory intervention. TENNCARE shall determine medical necessity of chronic ventilator care and tracheal suctioning other than short-term tracheal suctioning following recent ventilator weaning through the PAE process.

2.14.5.8 The CONTRACTOR shall provide authorization for Enhanced Respiratory Care (ERC) reimbursement rates based upon medical necessity. Prior to authorizing ERC reimbursement, the CONTRACTOR shall also confirm that the NF has an available bed licensed by the Tennessee Department of Health specifically for the provision of ventilator weaning or chronic ventilator care or tracheal suctioning, as applicable, and that authorizing reimbursement at those rates for a member to receive those services would not cause the facility to exceed the number of beds licensed for such specialized ERC on any given day. The CONTRACTOR must also provide authorizations for ERC reimbursement specific to the service being requested: ventilator weaning, chronic ventilator care, and/or tracheal



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suctioning. The CONTRACTOR shall not provide a broad ERC authorization that fails to specify which rate is being approved.

48. **Section 2.15.1.1.4 shall be deleted in its entirety and the remaining Section 2.15.1 shall be renumbered accordingly, including any references thereto.**

49. **Section 2.15.2.1 shall be deleted and replaced as follows:**

2.15.2.1 The CONTRACTOR shall have a QM/QI committee which shall include medical, behavioral health, and long-term care staff and contract providers (including medical, behavioral health, and long-term care providers). This committee shall analyze and evaluate the results of QM/QI activities, recommend policy decisions, ensure that providers are involved in the QM/QI program, institute needed action, and ensure that appropriate follow-up occurs.

50. **Section 2.15.3.1.1 shall be deleted and replaced as follows and Section 2.15.3.1.2 shall be deleted in its entirety.**

2.15.3.1.1 The two (2) clinical PIPs shall include one (1) in the area of behavioral health that is relevant to one of the Population Health programs for bipolar disorder, major depression, or schizophrenia and one (1) in the area of either child health or perinatal (prenatal/postpartum) health.

51. **Section 2.15.3.4 shall be deleted and replaced as follows:**

2.15.3.4 The CONTRACTOR shall report on PIPs as required in Section 2.30.12.2, Reporting Requirements. For Performance Improvement Project topics that are conducted in more than one region of the State, the CONTRACTOR shall submit one Performance Improvement Project Summary Report that includes region-specific data and information, including *G. Activity VIIa - Include improvement strategies* as required by CMS.

52. **Section 2.15.5 shall be amended by adding a new Section 2.15.5.5 which shall read as follows:**

2.15.5.5 The CONTRACTOR must submit the final hard copy NCQA Accreditation Report for each accreditation cycle within ten (10) days of receipt of the report from NCQA. Updates of accreditation status, based on annual HEDIS scores must also be submitted within ten (10) days of receipt.

53. **Section 2.15.7.1 shall be amended by adding a new Section 2.15.7.1.5 as follows:**

2.15.7.1.5 In the manner prescribed by TENNCARE, within twenty-four (24) hours of detection or notification, the CONTRACTOR must report to TENNCARE any death and/or any critical incident that could significantly impact the health and safety of a CHOICES member.

54. **Section 2.15.7.3.1 shall be amended by adding the phrase "QM/QI Program staff" as follows:**

2.15.7.3.1 The CONTRACTOR shall identify and track all significant Home Health Agency (HHA) critical incidents involving non-CHOICES enrollees. A HHA critical incident shall include



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those significant incidents that are reported to the CONTRACTOR from the HHA including unexpected death, major/severe injury, safety issues, or suspected physical, mental or sexual abuse or neglect. Each incident must be reported using the TENNCARE prescribed HHA Critical Incident report template within twenty-four (24) hours of the CONTRACTOR QM/QI Program staff receiving information relative to such an incident. An updated report, including results of investigation and next steps must be submitted to TENNCARE within thirty (30) calendar days of notification of the incident.

55. **Section 2.16.2 shall be deleted and replaced as follows:**

2.16.2 The prior approval of enrollee health education and outreach activities (see Section 2.7.4) provided through community outreach events may be waived when described in the CONTRACTOR's TennCare approved Annual Community Outreach Plan (see Section 2.7.4.2). If community events are added after submission and approval of the Annual Community Outreach Plan (CORP), a supplement to the Plan must be submitted and approved prior to implementation of the event.

56. **Section 2.17.2.8 shall be deleted and replaced as follows:**

2.17.2.8 All written member materials shall ensure effective communication with disabled/handicapped persons at no expense to the member and/or the member's representative. Effective Communication may be achieved by providing aids or services, including, but may not be limited to: Braille, large print and audio and shall be based on the needs of the individual member and/or the member's representative. The CONTRACTOR and its providers and direct service subcontractors shall be required to comply with the Americans with Disabilities Act of 1990 in the provision of auxiliary aids and services to members and/or the member's representative to achieve effective communication;

57. **Section 2.18.7.4 shall be deleted and replaced as follows:**

2.18.7.4 The CONTRACTOR shall conduct a statewide annual survey to assess provider satisfaction, including satisfaction with provider enrollment, provider communication, provider education, provider complaints, claims processing, claims reimbursement, care coordination, and utilization management processes, including medical reviews. The CONTRACTOR shall include TennCare Select enrollees together with BlueCare enrollees. The CONTRACTOR shall include questions specified by TENNCARE. The CONTRACTOR shall submit an annual report on the survey to TENNCARE as required in Section 2.30.13.3. The CONTRACTOR shall take action to address opportunities for improvement identified through the survey and provide an update on actions taken in the previous year to improve provider satisfaction. The survey shall be structured so that behavioral health provider satisfaction results and physical health provider satisfaction results, including any actions taken, can be separately stratified.



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58. **Section 2.21.6 shall be deleted and replaced as follows:**

2.21.6 Solvency Requirements

2.21.6.1 Minimum Net Worth

2.21.6.1.1 The CONTRACTOR shall comply with the Risk-Based Capital (RBC) requirements set forth in TCA 56-46-201 et seq. The CONTRACTOR shall demonstrate compliance with this provision to TDCI in the financial reports filed with TDCI by the CONTRACTOR.

2.21.6.2 Restricted Deposits

2.21.6.2.1 The CONTRACTOR shall establish and maintain restricted deposits in accordance with TCA 56-32-112(b).

2.21.6.3 If the CONTRACTOR fails to meet the applicable net worth and/or restricted deposit requirement, said failure shall constitute a hazardous financial condition and the CONTRACTOR shall be considered to be in breach of the terms of the Contract.



59. **Section 2.23.4.2.1 shall be deleted and replaced as follows:**

2.23.4.2.1 The CONTRACTOR shall submit encounter data that meets established TENNCARE data quality standards. These standards are defined by TENNCARE to ensure receipt of complete and accurate data for program administration and will be closely monitored and strictly enforced. TENNCARE will revise and amend these standards as necessary to ensure continuous quality improvement. The CONTRACTOR shall make changes or corrections to any systems, processes or data transmission formats as needed to comply with TENNCARE data quality standards as originally defined or subsequently amended. The CONTRACTOR shall comply with industry-accepted clean claim standards for all encounter data, including submission of complete and accurate data for all fields required on standard billing forms or electronic claim formats to support proper adjudication of a claim. In the event that the CONTRACTOR denies provider claims for reimbursement due to lack of sufficient or accurate data required for proper adjudication, the CONTRACTOR shall submit all available claim data to TENNCARE without alteration or omission. Where the CONTRACTOR has entered into capitated reimbursement arrangements with providers, the CONTRACTOR shall require submission of all utilization or encounter data to the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims (see Section 2.12.9.34); the CONTRACTOR shall require this submission from providers as a condition of the capitation payment and shall make every effort to enforce this contract provision to ensure timely receipt of complete and accurate data. The CONTRACTOR shall be required to submit all data relevant to the adjudication and payment of claims in sufficient detail, as defined by TENNCARE, in order to support comprehensive financial reporting and utilization analysis. The CONTRACTOR shall submit encounter data according to standards and formats as defined by TENNCARE, complying with standard code sets and maintaining integrity with all reference data sources including provider and member data. All encounter data submissions will be subjected to systematic data quality edits and audits on submission to verify not only the data content but also the accuracy of claims processing. Any batch submission which contains fatal errors that prevent processing or that does not satisfy defined threshold error rates will be rejected and returned to the CONTRACTOR for immediate correction. Re-submittals of rejected files, or notification of when the file will be resubmitted shall be completed within one (1) business day. Due to the need for timely data and to maintain integrity of processing sequence, should the CONTRACTOR fail to respond in accordance with this Section, the CONTRACTOR shall address any issues that prevent processing of an encounter batch in accordance with procedures specified in Section 2.23.13.

60. **Section 2.24.2 through 2.24.2.9 shall be deleted and replaced as follows:**

A.2.24.2 **Behavioral Health Advisory Committee**

The CONTRACTOR shall establish a behavioral health advisory committee that is accountable to the CONTRACTOR's governing body to provide input and advice regarding all aspects of the provision of behavioral health services according to the following requirements:

2.24.2.1 The CONTRACTOR's behavioral health advisory committee shall be comprised of at least fifty-one percent (51%) consumer and family representatives, of which the majority shall include individuals and/or families of those who may meet the clinical criteria of a priority enrollee;

2.24.2.2 There shall be geographic diversity;



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- 2.24.2.3 There shall be cultural and racial diversity;
- 2.24.2.4 There shall be representation by behavioral health providers, Certified Peer Recovery Specialists and/or Certified Family Support Specialists and consumers (or family members of consumers) of substance abuse services;
- 2.24.2.5 At a minimum, the CONTRACTOR's behavioral health advisory committee shall have input into policy development, planning for services, service evaluation, and member, family member and provider education;
- 2.24.2.6 Meetings shall be held at least quarterly and the CONTRACTOR shall keep a written record of all meetings;
- 2.24.2.7 The CONTRACTOR shall pay travel costs for the behavioral health advisory committee members who are consumers and family representatives;
- 2.24.2.8 The CONTRACTOR shall report on the activities of the CONTRACTOR's behavioral health advisory committee as required in Section 2.30.19.1; and
- 2.24.2.9 The CONTRACTOR shall provide orientation, at least annually, and ongoing training for behavioral health advisory committee members so they have sufficient information and understanding of behavioral health services to fulfill their responsibilities as advisors to the CONTRACTOR's governing body.

61. **Section 2.24.3.2 shall be deleted and replaced as follows:**

- 2.24.3.2 The CONTRACTOR's CHOICES advisory group shall include CHOICES members, member's representatives, advocates, and providers. At least fifty-one percent (51%) of the group shall be CHOICES members and/or their representatives (e.g., family members or caregivers) and the group shall include at least one active Money Follows the Person participant. The advisory group shall include representatives from nursing facility and CHOICES HCBS providers, including community-based residential alternative providers. The group shall reflect the geographic, cultural and racial diversity of each Grand Region covered by this Contract.



62. **Section 2.25.9 shall be amended by adding a new Section 2.25.9.10 as follows and renumbering the existing Section accordingly, including any references thereto.**

2.25.9.10 The CONTRACTOR shall, on an ongoing basis, monitor the quality of services provided by contracted facilities to individuals for whom the CONTRACTOR has authorized ERC reimbursement. Such monitoring shall include, but is not limited to: monthly review of ERC quality data submitted by facilities to TENNCARE and, beginning July 1, 2015, onsite review by a respiratory care practitioner with sufficient experience to adequately monitor the quality of care provided by the facility to each of the CONTRACTOR's members. When deficiencies are found upon assessment or through other means, the CONTRACTOR must immediately report those deficiencies to TENNCARE. If the deficiencies raise concerns about potential licensure rule violations, the CONTRACTOR must also report them to the Tennessee Department of Health within twenty four (24) hours of discovery to determine whether the NF has complied with licensure standards. Additionally, the CONTRACTOR must determine whether or not they will continue to contract with the NF for ERC reimbursement.

63. **Section 2.28.2 shall be deleted and replaced as follows:**

2.28.2 In order to demonstrate compliance with the applicable federal and state civil rights laws, guidance, and policies, including, but not limited to Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Titles II and III of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Church Amendments (42 U.S.C. 300a-7), Section 245 of the Public Health Service Act (42 U.S.C. 238n.), and the Weldon Amendment (Consolidated Appropriations Act 2008, Public Law 110-161, Div. G, Sec. 508 (d), 121 Stat. 1844, 2209), the CONTRACTOR shall designate a staff person to be responsible for non-discrimination compliance as required in Section 2.29.1.

64. **Section 2.29.1.3 shall be amended by adding a new Section 2.29.1.3.12 and deleting and replacing the renumbered Section 2.29.1.3.16 as follows and renumbering the remaining Section accordingly, including any references thereto.**

2.29.1.3.12 The CONTRACTOR shall maintain a minimum of one (1) dedicated CHOICES lead trainer. The CHOICES lead trainer shall be a part of the CONTRACTOR's management team, and shall be responsible for providing dedicated LTSS staff with current information on best practices and program enhancements or modifications, and attending meetings as requested by TENNCARE.

2.29.1.3.16 A full time staff person dedicated to and responsible for all QM/QI activities. This person shall be a physician or registered nurse licensed in the State of Tennessee and report to the local health plan;

65. **The renumbered Section 2.29.1.3 shall be amended by adding a new Section 2.29.1.3.25 through 2.29.1.3.25.5 as follows and renumbering the remaining Section accordingly, including any references thereto.**

2.29.1.3.25 A specialized member advocate for individuals with intellectual or other types developmental disabilities in each Grand Region in which the CONTRACTOR serves TennCare members.



Amendment 36 (cont.)

This member advocate shall be responsible for the internal representation of these members' interests, including, but not limited to, input into planning and delivery of services for individuals with I/DD, program monitoring and evaluation, and member, family, and provider education. The member advocate shall also be a resource for members concerning the following processes:

- 2.29.1.3.25.1 How to file a complaint with the member's MCO;
- 2.29.1.3.25.2 Facilitating resolution of any issues;
- 2.29.1.3.25.3 Making referrals to an appropriate CONTRACTOR staff;
- 2.29.1.3.25.4 Making recommendations to the CONTRACTOR on any changes needed to improve the CONTRACTOR's processes based on feedback from members with intellectual and other types of developmental disabilities; and
- 2.29.1.3.25.5 Making recommendations to TENNCARE regarding system or service improvements based on such feedback.

66. **The renumbered Section 2.29.1.3.26 through 2.29.1.3.26.7 shall be deleted and replaced as follows:**

- 2.29.1.3.26 Upon enrollment of members in CHOICES Group 2 and/or 3 (if and when directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3), a consumer advocate for CHOICES members. This person shall be responsible for internal representation of CHOICES members' interests including but not limited to input into planning and delivery of long-term care services, CHOICES QM/QI activities, program monitoring and evaluation, and member, family, and provider education. The consumer advocate shall also be a resource for CHOICES members concerning the following processes:
 - 2.29.1.3.26.1 How to file a complaint with the member's MCO;
 - 2.29.1.3.26.2 Facilitating resolution of any issues;
 - 2.29.1.3.26.3 How to change Care Coordinators;
 - 2.29.1.3.26.4 Making referrals to an appropriate CONTRACTOR staff;
 - 2.29.1.3.26.5 Making recommendations to the CONTRACTOR on any changes needed to improve the CONTRACTOR's processes based on feedback from CHOICES members;
 - 2.29.1.3.26.6 Making recommendations to TENNCARE regarding improvements for the CHOICES program; and
 - 2.29.1.3.26.7 Participating as an ex officio member of the CHOICES Advisory Group required in Section 2.24.3.



Amendment 36 (cont.)

67. **Section 2.30.5.1 shall be deleted and replaced as follows:**

2.30.5.1 The CONTRACTOR shall submit forty five (45) days after the end of the reporting period a quarterly *Population Health Update Report* addressing all seven (7) Population Health Programs (see Section 2.8.4 of this Contract). The report shall include process and operational data and any pertinent narrative to include any staffing changes, training or new initiatives occurring in the reporting period.

68. **Section 2.30.6 shall amended by adding a new Section 2.30.6.13 through 2.30.6.13.1 as follows:**

2.30.6.13. The CONTRACTOR shall submit a Housing Profile Assessment Report quarterly in a format specified by TENNCARE. This report shall monitor the housing needs of CHOICES enrollees waiting to transition or post-transition and includes, but is not limited to, transition wait times, transition barriers, monthly income amounts, housing options chosen, and counties chosen for transition.

2.30.6.13.1 The 4th Quarter submission will also include a brief narrative of the CONTRACTOR'S work strategy to create stronger networks and develop easier access to affordable housing. (See Section 2.11.6.7).

69. **Sections 2.30.11.1 and 2.30.11.7 shall be deleted in their entirety and the remaining Section 2.30.11 shall be renumbered accordingly, including any references thereto.**

70. **Section 2.30.12.1 and 2.30.12.2 shall be deleted and replaced as follows:**

2.30.12.1 Quality Report and Updates:

2.30.12.1.1 The CONTRACTOR shall submit, by July 30, 2015, a comprehensive *Quality Report* which addresses all program specific quality initiatives. The Quality Report will include, but not be limited to, the following for each initiative:

2.30.12.1.1.1 Title;

2.30.12.1.1.2 Description and rationale;

2.30.12.1.1.3 Initiation date;

2.30.12.1.1.4 End date when applicable;

2.30.12.1.1.5 Accountable staff;

2.30.12.1.1.6 Evaluation methodology; and

2.30.12.1.1.7 Results and conclusions.

2.30.12.1.2 Beginning in 2016, the CONTRACTOR shall submit, by January 30th and by July 30th of each year, a *Quality Report update* which addresses updates to each program specific quality initiative that have occurred during the previous six (6) months. The update will include, but not be limited to, the following for each initiative:



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- 2.30.12.1.2.1 Accountable staff, if changes occurred;
 - 2.30.12.1.2.2 Evaluation methodology, if changes occurred;
 - 2.30.12.1.2.3 Results and conclusions;
 - 2.30.12.1.2.4 The end date, when applicable;
 - 2.30.12.1.2.5 New quality initiatives (include all elements in 2.30.12.1).
 - 2.30.12.2 The CONTRACTOR shall submit an annual Report on Performance Improvement Projects that includes the information specified in Section 2.15.3. For Performance Improvement Project topics that are conducted in more than one region of the State, the CONTRACTOR shall submit one Performance Improvement Projects Summary Report that includes region-specific data and information, including improvement strategies. The report shall be submitted annually on July 30.
71. **Sections 2.30.13.3 and 2.30.13.4 shall be amended by deleting and replacing the last sentence as follows:**
- 2.30.13.3 The CONTRACTOR shall submit an annual Provider Satisfaction Survey Report that encompasses behavioral and physical health. The report shall summarize the provider survey methods and findings and must provide an analysis of opportunities for improvement (see Section 2.18.7.4) Beginning in 2016, the report shall be submitted by January 30 each year.
 - 2.30.13.4 The CONTRACTOR shall submit an annual CHOICES Provider Satisfaction Survey Report that addresses results for CHOICES long-term care providers. The report shall summarize the provider survey methods and findings, must provide an analysis of opportunities for improvement (see Section 2.18.7.5) in addition to CHOICES items specified in the protocols provided by TENNCARE. Beginning in 2016, the report shall be submitted by January 30 each year.
72. **Section 2.30.16.1.2 shall be deleted in its entirety including any references thereto.**
73. **Section 2.30.18.7 shall be deleted and replaced as follows:**
- 2.30.18.7 The CONTRACTOR shall submit a baseline *Business Continuity and Disaster Recovery (BC-DR)* plan for review and written approval as specified by TENNCARE. Thereafter, the CONTRACTOR shall submit, at a minimum, an annual update to their BC-DR. The CONTRACTOR shall communicate proposed modifications to the BC-DR plan at least fifteen (15) calendar days prior to their proposed incorporation. Such updates and/or modifications shall be subject to review and written approval by TENNCARE.
74. **Section 2.30.19.1 shall be deleted and replaced as follows:**
- 2.30.19.1 The CONTRACTOR shall submit a semi-annual Report on the Activities of the CONTRACTOR's Behavioral Health Advisory Committee regarding the activities of the behavioral health advisory committee established pursuant to Section 2.24.2.



Amendment 36 (cont.)

2.30.19.1.1 This report shall include the following information:

2.30.19.1.1.1 The current membership of the behavioral health advisory committee by name, address, role (e.g., consumer, provider, advocate, etc.) and organization represented);

2.30.19.1.1.2 Membership demographics as required by TENNCARE;

2.30.19.1.1.3 A description of any orientation and/or ongoing training activities for behavioral health advisory committee members;

2.30.19.1.1.4 Information on behavioral health advisory committee meetings, including the date, time, location, meeting attendees, and minutes from each meeting;

2.30.19.1.1.5 The report shall include a description of any new initiatives implemented by the CONTRACTOR during the reporting period based on the behavioral health advisory committee's input and advice to include, but not limited to, policy development, planning for services, service evaluation, and member, family member and provider education.

2.30.19.1.2 These reports shall be submitted to TENNCARE on March 1 and September 1 of each year.

75. **Section 4.9.1 shall be deleted and replaced as follows:**

4.9.1 In no event shall the maximum liability of the State under this Agreement during the original term of the Contract exceed three billion, eight hundred twenty eight million, five hundred seventy thousand, two hundred five dollars and ninety cents (\$3,828,570,205.90).

76. **Section 5.2.1 shall be amended by deleting and replacing the reference to “December 31, 2014” with “December 31, 2015” as follows:**

5.2.1 This Agreement, and its incorporated attachments, if any, as well as all Amendments to this Agreement, contain all of the terms and conditions agreed upon by the parties, and when executed by all parties, supersedes any prior agreements. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall be in effect from July 1, 2001, subject to approval by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The term of this Agreement shall expire on December 31, 2015. At the mutual agreement of TENNCARE and the CONTRACTOR, this Agreement shall be renewable for an additional twelve month period.

77. **Section 5.20.2.2.6.1 shall be amended by deleting and replacing the word “recommendations” with the word “requirements” as follows:**

5.20.2.2.6.1 In circumstances for which TENNCARE has applied this general liquidated damage to a notice of a deficiency that is related in any way to CHOICES care coordination processes and requirements which shall be determined by TENNCARE, the amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing requirements as specified in Section 2.9.6.11.9 of this Contract.

78. **The Liquidated Damages Chart in Section 5.20.2.2.7 shall be amended by deleting and replacing the phrase “Caseload and Staffing recommendations” with the phrase “Caseload and Staffing requirements” in each Level/Section it appears.**



79. The Liquidated Damages Chart in Section 5.20.2.2.7 shall be amended by deleting and replacing the existing Level A.32 and adding new Levels A.35 through A.38 as follows:

LEVEL	PROGRAM ISSUES	DAMAGE
A.32	Failure to ensure that a level of care (i.e., PAE) and supporting documentation, including the <i>Safety Determination Request Form</i> , if appropriate, submitted with the level of care is accurate and complete, satisfies all technical requirements specified by TENNCARE, and accurately reflects the member's current medical and functional status. (see Section 2.9.6.3.14)	\$2,000 per occurrence These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing requirements as specified in Section 2.9.6.11.9 of this Contract
A.35	Failure to complete and submit a safety determination request upon referral from TENNCARE or as part of ongoing care coordination pursuant to Sections 2.9.6.3.14.6 and 2.9.6.9.2.1.13	\$500 per day after five (5) business days from the notification of referral from TENNCARE if the CONTRACTOR has not submitted a completed safety determination request to TENNCARE pursuant to 2.9.6.3.14.6. \$2,000 per occurrence for safety determination requests not completed and submitted to TENNCARE during ongoing care coordination pursuant to 2.9.6.9.2.1.13. These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing requirements as specified in Section 2.9.6.11.9 of this Contract
A.36	Failure to complete the PAE process and/or ensure that a PAE is submitted to TENNCARE within twenty (20) business days of the face-to-face visit, per Section 2.9.6.14, on all referrals, except those individuals who are screened out who do not subsequently request to continue the intake process or individuals who choose to terminate the intake process, which must be documented in writing	\$500 per day beginning twenty (20) business days after completion of the face-to-face visit until date of PAE submission



A.37	Failure to conduct and submit level of care reassessments pursuant to the requirements in Sections 2.9.6.9.3.1.1 and 2.9.6.9.3.1.1.3.2	\$500 per day, per occurrence for each applicable timeline violated in Sections 2.9.6.9.3.1.1 and 2.9.6.9.3.1.1.3.2. These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing requirements as specified in Section 2.9.6.11.9 of this Contract
A.38	Failure to report deficiencies related to ERC threshold standards of care and licensure rule violations to the Tennessee Department of Health within twenty-four (24) hours of discovery	\$500 per day beginning twenty-four (24) hours after the discovery of the deficiency if the deficiency is not reported within twenty-four (24) hours to the Tennessee Department of Health (See Section 2.25.9.10)

80. **Attachment V shall be amended by deleting and replacing the Geographic Access Requirement for the Service Types: “24 Hour Psychiatric Residential Treatment”, “24 Hour Residential Treatment Services (Substance Abuse)” and “Crisis Services (Mobile)” as follows:**

Service Type	Geographic Access Requirement	Maximum Time for Admission/ Appointment
24 Hour Psychiatric Residential Treatment	The CONTRACTOR shall contract with at least 1 provider of service in each Grand Region (3 statewide) for ADULT members ----- Travel distance does not exceed 60 miles for at least 75% of CHILD members and does not exceed 90 miles for at least 90% of CHILD members	Within 30 calendar days

Service Type	Geographic Access Requirement	Maximum Time for Admission/ Appointment
24 Hour Residential Treatment Services (Substance Abuse)	The CONTRACTOR shall contract with at least 1 provider of service in each Grand Region (3 statewide) for ADULT members ----- The CONTRACTOR shall contract with at least 1 provider of service in each Grand Region (3 statewide) for CHILD members	Within 10 business days



Service Type	Geographic Access Requirement	Maximum Time for Admission/ Appointment
Crisis Services (Mobile)	Not subject to geographic access standards	Face-to-face contact within 2 hours for emergency situations and 4 hours for urgent situations

81. **Sections A.4.3.1.2.4, A.4.3.2.4.5 and A.8.2.2.4 of Attachment XI shall be amended by deleting the word “mental” and replacing it with the words “behavioral health”.**

82. **Section A.4.6.1 of Attachment XI shall be deleted and replaced as follows:**

A.4.6.1 The CONTRACTOR shall conduct random pre-transportation validation checks prior to the member receiving the services in order to prevent fraud and abuse. The amount validated shall be two percent (2%) of NEMT scheduled trips per month.

83. **Section A.5.2 of Attachment XI shall be amended by adding a new Section A.5.2.3 which shall read as follows:**

A.5.2.3 Members shall not be required to arrive at their scheduled appointment more than one (1) hour before their appointment time. Members shall not be dropped off for their appointment before the provider’s office or facility has opened their doors.

84. **Sections A.6.4 and A.6.5 of Attachment XI shall be deleted and replaced as follows:**

A.6.4 The CONTRACTOR shall ensure that members arrive at pre-arranged times for appointments and are picked up at pre-arranged times for the return leg of the trip. If there is no pre-arranged time for the return leg of the trip, the CONTRACTOR shall ensure that members are picked up within one (1) hour after notification Pick-up and drop-off times should be captured in such a way to allow reporting as requested by TENNCARE. Members shall not be required to arrive at their scheduled appointment more than one (1) hour before their appointment time. Members shall not be dropped off for their appointment before the provider’s office or facility has opened their doors.

A.6.5 The CONTRACTOR shall ensure that the waiting time for members for pick-up does not exceed ten (10) minutes past the scheduled pick-up time. Scheduled pick-up times shall allow the appropriate amount of travel time to assure the members arrive giving them sufficient time to check-in for their appointment. Members shall be dropped off for their appointment no less than fifteen (15) minutes prior to their appointment time to prevent the drop off time from being considered a late drop off.

85. **Paragraphs A.8.3.6 through A.8.3.8, A.8.3.11 and A.8.3.12 of Attachment XI shall be deleted and replaced as follows:**

A.8.3.6 The CONTRACTOR shall ensure that all drivers pass a physical examination prior to providing services under the Contract and have additional physical examinations as necessary



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to ensure that a driver is qualified to drive a passenger vehicle (e.g., if the driver has a heart attack or stroke). The physical examination shall be at least as extensive as the medical examination required by the United States Department of Transportation's Federal Motor Carrier Safety Administration (FMCSA) for commercial drivers. Proof of exams shall be maintained in the driver file as to allow for unscheduled file audits. All driver files (including but not limited to, HRAs, private vendor's, etc.) must contain an attestation signed by the driver including the effective dates of the physical examination.

A.8.3.7 The CONTRACTOR shall ensure that all drivers pass a drug and alcohol test prior to providing services under the Agreement. In addition, the CONTRACTOR shall ensure that an alcohol and drug test is conducted when a trained supervisor/employer of a driver has reasonable suspicion to believe that the driver has violated the CONTRACTOR's policies and procedures regarding use of alcohol and/or controlled substances, that random drug and alcohol tests are conducted, and that post accident drug and alcohol testing is conducted. The CONTRACTOR's policies and procedures for drug and alcohol testing shall, at a minimum, meet the FMCSA's alcohol and drug testing requirements for motor carriers. Drivers should be randomly selected from the current utilized drivers for drug and alcohol testing with no less than twenty percent (20%) of drivers tested per calendar year. The drivers tested shall be reported to TENNCARE quarterly as described in the reporting section of this Attachment XI. Results of drug and alcohol testing shall be maintained in the driver's file as to allow for unscheduled file audits. All driver files (including but not limited to, HRAs, private vendor's, etc.) must contain an attestation signed by the driver containing the date of the drug and alcohol test.

A.8.3.8 The CONTRACTOR shall ensure that criminal background checks pursuant to TCA 38-6-109 as well as national criminal background checks are conducted for all drivers prior to providing services under the Agreement and every five years thereafter. The CONTRACTOR shall develop a list of disqualifying criminal offenses, which at a minimum shall include the permanent and interim disqualifying criminal offenses that apply to applicants for a hazardous materials endorsement in Tennessee. Drivers that have been convicted, pled guilty or found not guilty by reason of insanity of any of the disqualifying criminal offenses shall not provide services under the Agreement. Results of background checks shall be maintained in the drivers file as to allow for unscheduled file audits.

A.8.3.11 The CONTRACTOR shall verify that drivers are not listed on the Tennessee Sexual Offender Registry and the equivalent registry showing data from all fifty (50) states. This is in addition to the criminal background check and results shall be maintained in the driver's file as to allow for unscheduled file audits.

A.8.3.12 The CONTRACTOR shall ensure that drivers maintain an acceptable Motor Vehicle Report containing data for any state the driver has previously lived prior to providing services under the Agreement and annually thereafter. Annual updates shall only contain information for the states the driver has resided in since the last update. The Motor Vehicle Report shall, at a minimum, show the following:

86. Section A.14.3.1 of Attachment XI shall be deleted and replaced as follows:

A.14.3.1 The CONTRACTOR shall conduct post validation checks by matching NEMT billed claims to Healthcare provider billed claims validating two percent (2%) of NEMT claims received in



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a month and if the CONTRACTOR determines that transportation for a particular member was not to a TennCare covered service, the CONTRACTOR validates the next three (3) requests for that member before approving the requested trip (see Section A.4.6 of this Attachment)). If the CONTRACTOR suspects fraud or abuse, it shall comply with the fraud and abuse requirements of the Contract. The CONTRACTOR may exclude services when conducting post-validation in which billing of those services as appropriate (e.g., Pre-natal visits) cannot not be validated in the required timeframe.

87. Sections A.17.4.1 and A.17.4.3 shall be deleted and replaced as follows:

A.17.4.1 The CONTRACTOR shall have policies and procedures for ensuring that an appropriate corrective action is taken when a NEMT provider furnishes inappropriate or substandard services, when a NEMT provider does not furnish services that should have been furnished, or when a NEMT provider is out of compliance with federal, state, or local law. The CONTRACTOR shall provide notification of the corrective action initiated between the CONTRACTOR and their NEMT provider as they occur.

A.17.4.3 As required in Section A.19.5.72 of this Attachment, the CONTRACTOR shall report on monitoring activities, monitoring findings, corrective actions taken, and improvements made.

88. Attachment XI shall be amended by deleting and replacing Section A.19.1.2 and adding a new Section A.19.1.3 as follows:

A.19.1.2 Pick-up and Delivery Standards Report. The CONTRACTOR shall submit a monthly report that documents the scheduled pick-up time, actual pick-up time, members appointment time, time the member was dropped-off for the appointment, pre-arranged return pick-up time, time the member requested pick-up (if not pre-arranged), actual return pick-up time and time the member arrived at their final destination.

A.19.1.3 Drug and Alcohol Testing Report. The CONTRACTOR shall submit a quarterly report providing a listing of drivers who have been drug and alcohol tested during the reporting period. A minimum of five percent (5%) of drivers should be reported each quarter. The report shall include, at minimum, the name of the driver tested for drugs and alcohol, name of the provider that the driver is contracted with, social security number of the driver, date the driver was authorized to transport and the date the test was conducted. Drivers' drug and alcohol test should be current within the last five (5) years.

89. Definition Number 11, 15 and 18 of Exhibit A in Attachment XI shall be deleted and replaced as follows:

11. **Private Automobile:** An enrollee's personal vehicle or the personal vehicle of a family member or friend, to which the enrollee has access.

15. **Tennessee Department of Intellectual and Developmental Disabilities (DIDD):** The state agency responsible for providing services and supports to Tennesseans with intellectual and developmental disabilities. DIDD is a division of the Tennessee Department of Finance and Administration.



Amendment 36 (cont.)

18. Urgent Trip: Covered NEMT services required for an unscheduled episodic situation in which there is no immediate threat to life or limb but the enrollee must be seen on the day of the request (can be one (1) or multiple trip legs). At a minimum, these shall be considered urgent trips: Hospital and Crisis Stabilization Unit discharges and same-day appointments with outpatient behavioral health providers.

90. **The “Performance Standard” and “Liquidated Damage” in Item number 6 of Exhibit F in Attachment XI shall be amended by adding additional text as follows:**

No.	PERFORMANCE STANDARD	LIQUIDATED DAMAGE
6	<p>Comply with driver training requirements and driver standards (see Section A.8 of this Attachment)</p> <p>Comply with driver requirements as it relates to drug and alcohol testing</p>	<p>\$2,500 per calendar day per driver for each calendar day that a driver is not in compliance with the driver standards</p> <p>The following sanctions are specifically for drug and alcohol standards for NEMT drivers. For the first deficiency: \$5,000 for failure to meet the five (5%) requirement for drug and alcohol testing per quarter. For the second deficiency: \$7,500 for failure to meet the five (5%) requirement for drug and alcohol testing per quarter. For the third and subsequent deficiencies: \$10,000 for failure to meet the five (5%) requirement for drug and alcohol testing per quarter</p>

91. **The Liquidated Damage in Item number 11 of Exhibit F in Attachment XI shall be amended by deleting the word “quarter” and replacing it with the words “reporting period”.**

92. **The “Performance Standard and Liquidated Damage” Chart in Exhibit F of Attachment XI shall be amended by adding a new Item 13 as follows:**

No.	PERFORMANCE STANDARD	LIQUIDATED DAMAGE
13	<p>Failure by the CONTRACTOR to comply with the pre-validation requirements and the post-validation requirements (see Section A.4.6 and Section A.14.3 of this Attachment XI)</p>	<p>\$5,000 for failure to meet the 2% benchmark for pre-validations of NEMT scheduled trips</p> <p>\$1,000 for failure to meet the 2% benchmark for post-validations of NEMT trips; and \$100 per calendar day until an acceptable report has been received by TENNCARE beginning on the date the CONTRACTOR is notified of the deficiency</p>



93. **Attachment XIII shall be amended by adding a new Item VI as follows:**

VI. **Administrative Fee for Claims for Persons with Suspended Eligibility**

The CONTRACTOR shall be paid two dollars (\$2.00) per claim as reimbursement for processing claims for services incurred as described in Section 2.4.4.6 of this Contract. Actual expenditures for the services and the allowed amount for claims processing are subject to TCA 56-32-124. The CONTRACTOR shall prepare checks for payment of providers for the provision of the services incurred as described in Section 2.4.4.6. The CONTRACTOR shall notify the State of the amount to be paid in a mutually acceptable form and format at least forty-eight (48) hours in advance of distribution of any provider payment related to this requirement. TENNCARE shall remit payment to the CONTRACTOR in an amount equal to: the amount to be paid to providers; plus, two dollars (\$2.00) per claim processed by the CONTRACTOR; plus, an amount sufficient to cover any payment due in accordance with TCA 56-32-124 within forty-eight (48) hours of receipt of notice. The CONTRACTOR shall then release payments to providers within twenty-four (24) hours of the receipt of funds from the State. The CONTRACTOR is responsible for any payments required pursuant to TCA 56-32-124.



Amendment 36 (cont.)

All of the provisions of the original Contract not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective January 1, 2015.

The State is not bound by this Amendment until it is signed by the contract parties and approved by appropriate officials in accordance with applicable Tennessee laws and regulations (depending upon the specifics of this Contract, said officials may include, but are not limited to, the Commissioner of Finance and Administration, the Commissioner of Human Resources, and the Comptroller of the Treasury).

The CONTRACTOR, by signature of this Amendment, hereby affirms that this Amendment has not been altered and therefore represents the identical document that was sent to the CONTRACTOR by TENNCARE.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

VOLUNTEER STATE HEALTH PLAN, INC.

BY: Larry B. Martin / cd
Larry B. Martin
Commissioner

BY: Amber Cambron
Amber Cambron
President & CEO VSHP

DATE: 12/17/14

DATE: 12/10/14

CONTRACT SUMMARY SHEET



RFS Number:	31866-00026	Edison #	29635	Contract Number:	FA-02-14632-35
State Agency:	Department of Finance and Administration			Division:	Bureau of TennCare
Contractor				Contract Identification Number	
VSHP (TennCare Select)				<input type="checkbox"/> V- <input type="checkbox"/> C-	Edison Vendor #0000071694

Service Description

Managed Care Organization / Medically Necessary Health Care Services to the TennCare/Medicaid Population

Contract Begin Date	Contract End Date
7/1/2001	12/31/2014

Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66		134	11	<input type="checkbox"/> STARS		
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)	
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$ 18,599,868.48	
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$ 33,079,942.80	
2004	\$ 25,125,990.72	\$ 38,364,165.90			\$ 63,490,156.62	
2005	\$ 58,007,447.00	\$ 58,007,447.00			\$ 116,014,894.00	
2006	\$ 87,748,111.00	\$ 87,748,111.00			\$ 175,496,222.00	
2007	\$ 87,748,111.00	\$ 87,748,111.00			\$ 175,496,222.00	
2008	\$ 72,610,000.00	\$ 127,390,000.00			\$ 200,000,000.00	
2009	\$ 72,610,000.00	\$ 127,390,000.00			\$ 200,000,000.00	
2010	\$ 100,882,479.00	\$ 304,024,121.00			\$ 404,906,600.00	
2011	\$ 131,085,619.00	\$ 312,820,981.00			\$ 443,906,600.00	
2012	\$ 149,893,942.00	\$ 294,012,658.00			\$ 443,906,600.00	
2013	\$ 150,102,578.00	\$ 293,804,022.00			\$ 443,906,600.00	
2014	\$ 153,147,777.00	\$ 290,758,823.00			\$ 443,906,600.00	
2015	\$ 77,539,385.00	\$ 144,413,915.00			\$ 221,953,300.00	
Total:	\$ 1,189,042,500.35	\$ 2,195,621,105.55			\$ 3,384,663,605.90	

CFDA#	93.778 Title XIX Dept. of Health & Human Svcs.	Check the box ONLY if the answer is YES:	
State Fiscal Contract		Is the Contractor a SUBRECIPIENT? (per OMB A-133)	
Name:	Casey Dungan	Is the Contractor a Vendor? (per OMB A-133)	
Address:	310 Great Circle Road	Is the Fiscal Year Funding STRICTLY LIMITED?	
Phone:	Nashville, TN (615)507-6482	Is the Contractor on STARS?	
Procuring Agency Budget Officer Approval Signature		Is the Contractor's FORM W-9 ATTACHED?	
Casey Dungan		Is the Contractor's Form W-9 Filed with Accounts?	

COMPLETE FOR ALL AMENDMENTS (only)			Funding Certification
	Base Contract & Prior Amendments	This Amendment ONLY	Funding Certification (certification, required by T.C.A., § 9-4-5113, that there is a balance in the appropriation from which the obligated expenditure is required to be paid that is not otherwise encumbered to pay obligations previously incurred)
CONTRACT END DATE:	12/31/2014		
FY: 2002	\$ 18,599,868.48		
FY: 2003	\$ 33,079,942.80		
FY: 2004	\$ 63,490,156.62		
FY: 2005	\$ 116,014,894.00		
FY: 2006	\$ 175,496,222.00		
FY: 2007	\$ 175,496,222.00		
FY: 2008	\$ 200,000,000.00		
FY: 2009	\$ 200,000,000.00		
FY: 2010	\$ 404,906,600.00		
FY: 2011	\$ 443,906,600.00		
FY: 2012	\$ 443,906,600.00		
FY: 2013	\$ 443,906,600.00		
FY: 2014	\$ 443,906,600.00		
FY: 2015	\$ 221,953,300.00		
Total:	\$ 3,384,663,605.90		



AMENDMENT NUMBER 35

**AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN**

THE STATE OF TENNESSEE,

d.b.a.

TENNCARE AND

VOLUNTEER STATE HEALTH PLAN, INC.

CONTRACT NUMBER: FA-02-14632-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as specified below.

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. Contract Section 4.6 shall be deleted in its entirety and replaced with amended Section 4.6 as follows:

4.6 HEALTH INSURER FEE

- 4.6.1. The CONTRACTOR and TENNCARE acknowledge that the CONTRACTOR is subject to a Health Insurer Fee (HIF) imposed by the federal government under the Patient Protection and Affordable Care Act (PPACA) of 2010. The CONTRACTOR is responsible for payment of a percentage of the Health Insurer Fee for all health insurance providers. The CONTRACTOR'S obligation is determined by the ratio of the CONTRACTOR'S net written premiums for the preceding year compared to the total net written premiums of all covered entities subject to the Health Insurer Fee for the same year.
- 4.6.2. The amount of the Health Insurer Fee attributable to the CONTRACTOR and attributable to the CONTRACTOR'S premiums under this Contract could affect the actuarial soundness of the premiums received by the CONTRACTOR from TENNCARE for the period during which the Health Insurer Fee is assessed. To preserve the actuarially sound administrative rate payments, TENNCARE shall reimburse the CONTRACTOR for the amount of the Health Insurer Fee, including an actuarially sound adjustment for the estimated impact of the non-deductibility of the Health Insurer Fee for Federal and State tax purposes, specifically attributable to the CONTRACTOR'S TENNCARE membership.
- 4.6.3. The monthly administrative rates will be paid excluding the amount for the Health Insurer Fee. Once the CONTRACTOR'S Health Insurer Fee amount is known, TENNCARE will determine the amount this is as a percent of the administrative amount paid in the previous fiscal year using the aggregate member months for the fiscal year as of the July following the fiscal year and the administrative rates paid for the fiscal year. TENNCARE will then calculate the amount owed to the CONTRACTOR, including any adjustments for Federal and State taxes, in aggregate for the 12 month fiscal year and pay the administrative amount adjustment as a single payment. The amount attributable to the CONTRACTOR'S TENNCARE membership shall be determined based on the CONTRACTOR'S final Form 8963 filing, the final notification of the Health Insurer Fee amount owed by the CONTRACTOR received from the United States Internal Revenue Service, and supporting documentation from the CONTRACTOR as requested by TENNCARE.



Amendment 35 (cont.)

4.6.4. TENNCARE shall complete its calculation of the amount owed to the CONTRACTOR within ninety (90) days of its receipt of the final notification and supporting documentation from the CONTRACTOR. Payment is contingent on the availability of State funds and CMS approval of the administrative rates including the Health Insurer Fee adjustment. The administrative rates excluding the Health Insurer Fee adjustment will be included in the contracts and, following payment of the amount owed to the CONTRACTOR, separate rates will be added that contain the administrative rate adjustment to reflect the Health Insurer Fee.

All of the provisions of the original Contract not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective September 15, 2014.

The State is not bound by this Amendment until it is signed by the contract parties and approved by appropriate officials in accordance with applicable Tennessee laws and regulations (depending upon the specifics of this Contract, said officials may include, but are not limited to, the Commissioner of Finance and Administration, the Commissioner of Human Resources, and the Comptroller of the Treasury).

The CONTRACTOR, by signature of this Amendment, hereby affirms that this Amendment has not been altered and therefore represents the identical document that was sent to the CONTRACTOR by TENNCARE.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

VOLUNTEER STATE HEALTH PLAN, INC.

BY: Larry B. Martin / CD
Larry B. Martin
Commissioner

BY: Scott C. Pierce
Scott C. Pierce
President & CEO VSHP

DATE: 9/5/2014

DATE: 8/26/14

CONTRACT SUMMARY SHEET



RFS Number:	31866-00026	Edison #	29635	Contract Number:	FA-02-14632-34
State Agency:	Department of Finance and Administration			Division:	Bureau of TennCare
Contractor				Contract Identification Number	
VSHP (TennCare Select)				<input type="checkbox"/> V- <input type="checkbox"/> C-	Edison Vendor #0000071694

Service Description

Managed Care Organization / Medically Necessary Health Care Services to the TennCare/Medicaid Population

Contract Begin Date	Contract End Date
7/1/2001	12/31/2014

Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66		134	11	<input type="checkbox"/> STARS		
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)	
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$ 18,599,868.48	
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$ 33,079,942.80	
2004	\$ 25,125,990.72	\$ 38,364,165.90			\$ 63,490,156.62	
2005	\$ 58,007,447.00	\$ 58,007,447.00			\$ 116,014,894.00	
2006	\$ 87,748,111.00	\$ 87,748,111.00			\$ 175,496,222.00	
2007	\$ 87,748,111.00	\$ 87,748,111.00			\$ 175,496,222.00	
2008	\$ 72,610,000.00	\$ 127,390,000.00			\$ 200,000,000.00	
2009	\$ 72,610,000.00	\$ 127,390,000.00			\$ 200,000,000.00	
2010	\$ 100,882,479.00	\$ 304,024,121.00			\$ 404,906,600.00	
2011	\$ 131,085,619.00	\$ 312,820,981.00			\$ 443,906,600.00	
2012	\$ 149,893,942.00	\$ 294,012,658.00			\$ 443,906,600.00	
2013	\$ 150,102,578.00	\$ 293,804,022.00			\$ 443,906,600.00	
2014	\$ 153,147,777.00	\$ 290,758,823.00			\$ 443,906,600.00	
2015	\$ 77,539,385.00	\$ 144,413,915.00			\$ 221,953,300.00	
Total:	\$ 1,189,042,500.35	\$ 2,195,621,105.55			\$ 3,384,663,605.90	

CFDA#	93.778 Title XIX Dept. of Health & Human Svcs.	Check the box ONLY if the answer is YES:
State Fiscal Contract		
Name:	Casey Dungan	Is the Contractor a SUBRECIPIENT? (per OMB A-133)
Address:	310 Great Circle Road	Is the Contractor a Vendor? (per OMB A-133)
Phone:	Nashville, TN (615)507-6482	Is the Fiscal Year Funding STRICTLY LIMITED?
Procuring Agency Budget Officer Approval Signature		Is the Contractor on STARS?
Casey Dungan		Is the Contractor's FORM W-9 ATTACHED?
		Is the Contractor's Form W-9 Filed with Accounts?

COMPLETE FOR ALL AMENDMENTS (only)			Funding Certification
	Base Contract & Prior Amendments	This Amendment ONLY	
CONTRACT END DATE:	12/31/2014		Funding Certification (certification, required by T.C.A., § 9-4-5113, that there is a balance in the appropriation from which the obligated expenditure is required to be paid that is not otherwise encumbered to pay obligations previously incurred)
FY: 2002	\$ 18,599,868.48		
FY: 2003	\$ 33,079,942.80		
FY: 2004	\$ 63,490,156.62		
FY: 2005	\$ 116,014,894.00		
FY: 2006	\$ 175,496,222.00		
FY: 2007	\$ 175,496,222.00		
FY: 2008	\$ 200,000,000.00		
FY: 2009	\$ 200,000,000.00		
FY: 2010	\$ 404,906,600.00		
FY: 2011	\$ 443,906,600.00		
FY: 2012	\$ 443,906,600.00		
FY: 2013	\$ 443,906,600.00		
FY: 2014	\$ 443,906,600.00		
FY: 2015	\$ 221,953,300.00		
Total:	\$ 3,384,663,605.90		



AMENDMENT NUMBER 34

**AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.**

CONTRACT NUMBER: FA-02-14632-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as specified below.

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

- 1. Section 4 shall be amended by adding a new Section 4.6 as follows, renumbering the remaining Section 4 accordingly and updating any references thereto:**

4.6 HEALTH INSURER FEE

- 4.6.1** The Health Insurer Fee (HIF), under section 9010 of the Patient Protection and Affordable Care Act of 2010, will come due in September each year for the premiums paid the previous calendar year. TENNCARE will reimburse the CONTRACTOR the full cost of the HIF that the CONTRACTOR incurs and becomes obligated to pay due to its receipt of TennCare premiums pursuant to this Contract. The full cost of the Health Insurer Fee will include both the HIF and the allowance to reflect any tax liabilities related to the corresponding HIF CONTRACTOR's obligation. This amount will be calculated in an actuarially sound manner consistent with the requirements of 42 CFR 438.6(c).
- 4.6.2** To facilitate this payment the CONTRACTOR shall provide TENNCARE with the HIF assessment received from the Internal Revenue Service (IRS) and the pro rata portion attributed to the CONTRACTOR's administrative payments under its contracts(s) for the preceding calendar year. In addition the CONTRACTOR will provide TENNCARE either a copy of its Federal tax filing for the year of the HIF in question or a certified statement from its Chief Financial Officer as to the Federal Tax Rate that the CONTRACTOR incurred on taxable income for the past three years.
- 4.6.3** The State's share of the HIF and the CONTRACTOR's federal tax information shall be submitted to TENNCARE as soon as practicable but in no event more than fourteen (14) days after receipt of the IRS final fee calculation for each year the HIF is assessed. TENNCARE will make a one-time payment to the CONTRACTOR for the State's share of the HIF and the allowance to reflect the federal income tax liability related to the corresponding HIF CONTRACTOR's obligation within thirty (30) days of the receipt of the CONTRACTOR's tax information.



Amendment 34 (cont.)

All of the provisions of the original Contract not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective August 1, 2014.

The State is not bound by this Amendment until it is signed by the contract parties and approved by appropriate officials in accordance with applicable Tennessee laws and regulations (depending upon the specifics of this Contract, said officials may include, but are not limited to, the Commissioner of Finance and Administration, the Commissioner of Human Resources, and the Comptroller of the Treasury).

The CONTRACTOR, by signature of this Amendment, hereby affirms that this Amendment has not been altered and therefore represents the identical document that was sent to the CONTRACTOR by TENNCARE.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

BY: Larry B. Martin/CD
Larry B. Martin
Commissioner

DATE: 6/20/14

VOLUNTEER STATE HEALTH PLAN, INC.

BY: Scott C. Pierce
Scott C. Pierce
President & CEO VSHP

DATE: 6/16/14

CONTRACT SUMMARY SHEET



RFS Number: 31866-00026		Edison # 29635		Contract Number: FA-02-14632-33		
State Agency: Department of Finance and Administration			Division: Bureau of TennCare			
Contractor			Contract Identification Number			
VSHP (TennCare Select)			<input type="checkbox"/> V- <input type="checkbox"/> C- Edison Vendor #0000071694			
Service Description						
Managed Care Organization / Medically Necessary Health Care Services to the TennCare/Medicaid Population						
Contract Begin Date			Contract End Date			
7/1/2001			12/31/2014			
Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66		134	11	<input type="checkbox"/> STARS		
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)	
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$ 18,599,868.48	
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$ 33,079,942.80	
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2005	\$ 58,007,447.00	\$ 58,007,447.00			\$ 116,014,894.00	
2006	\$ 87,748,111.00	\$ 87,748,111.00			\$ 175,496,222.00	
2007	\$ 87,748,111.00	\$ 87,748,111.00			\$ 175,496,222.00	
2008	\$ 72,610,000.00	\$ 127,390,000.00			\$ 200,000,000.00	
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2011	\$ 131,085,619.00	\$ 312,820,981.00			\$ 443,906,600.00	
2012	\$ 149,893,942.00	\$ 294,012,658.00			\$ 443,906,600.00	
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2014	\$ 153,147,777.00	\$ 290,758,823.00			\$ 443,906,600.00	
2015	\$ 77,539,385.00	\$ 144,413,915.00			\$ 221,953,300.00	
Total:	\$ 1,189,042,500.35	\$ 2,195,621,105.55			\$ 3,384,663,605.90	
CFDA#	93.778 Title XIX Dept. of Health & Human Svcs.			Check the box ONLY if the answer is YES:		
State Fiscal Contract				Is the Contractor a SUBRECIPIENT? (per OMB A-133)		
Name:	Casey Dungan		Nashville, TN		Is the Contractor a Vendor? (per OMB A-133)	
Address:	310 Great Circle Road				Is the Fiscal Year Funding STRICTLY LIMITED?	
Phone:	(615)507-6482				Is the Contractor on STARS?	
Procuring Agency Budget Officer Approval Signature				Is the Contractor's FORM W-9 ATTACHED?		
Casey Dungan 				Is the Contractor's Form W-9 Filed with Accounts?		
COMPLETE FOR ALL AMENDMENTS (only)			Funding Certification			
CONTRACT END DATE:		Base Contract & Prior Amendments	This Amendment ONLY		Funding Certification (certification, required by T.C.A., § 9-4-5113, that there is a balance in the appropriation from which the obligated expenditure is required to be paid that is not otherwise encumbered to pay obligations previously incurred)	
		12/31/2014				
FY: 2002		\$ 18,599,868.48				
FY: 2003		\$ 33,079,942.80				
FY: 2004		\$ 63,490,156.62				
FY: 2005		\$ 116,014,894.00				
FY: 2006		\$ 175,496,222.00				
FY: 2007		\$ 175,496,222.00				
FY: 2008		\$ 200,000,000.00				
FY: 2009		\$ 200,000,000.00				
FY: 2010		\$ 404,906,600.00				
FY: 2011		\$ 443,906,600.00				
FY: 2012		\$ 443,906,600.00				
FY: 2013		\$ 443,906,600.00				
FY: 2014		\$ 443,906,600.00				
FY: 2015		\$ -	\$ 221,953,300.00			
Total:		\$ 3,162,710,305.90	\$ 221,953,300.00			



AMENDMENT NUMBER 33

AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.

CONTRACT NUMBER: FA-02-14632-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as specified below.

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. Section 1 shall be amended by modifying and adding the following definitions and deleting the definition for Immediate Eligibility for CHOICES Group 2:

Back-up Plan – A written plan that is a required component of the plan of care for all CHOICES members receiving companion care or non-residential CHOICES HCBS in their own home and which specifies unpaid persons as well as paid consumer-directed workers and/or contract providers (as applicable) who are available, have agreed to serve as back-up, and who will be contacted to deliver needed care in situations when regularly scheduled CHOICES HCBS providers or workers are unavailable or do not arrive as scheduled. A CHOICES member or his/her representative may not elect, as part of the back-up plan, to go without services. The back-up plan shall include the names and telephone numbers of persons and agencies to contact and the services to be provided by each of the listed contacts. The member and his/her representative (as applicable) shall have primary responsibility for the development and implementation of the back-up plan for consumer directed services. The FEA will assist as needed with the development and verification of the initial back-up plan for consumer direction. The care coordinator shall be responsible for assistance as needed with implementing the back-up plan and for updating and verifying the back-up plan on an ongoing basis.

Supports Broker – An individual assigned by the FEA to each CHOICES member participating in consumer direction who assists the member/representative as needed in performing certain employer of record functions as follows: developing job descriptions; recruiting, interviewing, and hiring workers; member and worker enrollment in consumer direction and consumer direction training; and developing (as part of the onboarding process for new workers) a schedule for the member's workers that comports with the schedule at which services are needed by the member as reflected in the plan of care. . The supports broker shall also assist the member as needed with developing and verifying the initial back-up plan for consumer direction. The supports broker collaborates with the member's care coordinator, as appropriate. The supports broker does not have authority or responsibility for consumer direction. The member or member's representative must retain authority and responsibility for consumer direction.



Amendment 33 (cont.)

Wellness – An approach to health care that emphasizes not merely the absence of disease or infirmity but the pursuit of optimum health. It is an active process of helping members become aware of and make choices that will help them to achieve a healthy and more fulfilling life. Wellness includes preventing illness, prolonging life, and improving quality of life, as opposed to focusing solely on treating diseases. Wellness is a condition of good physical and mental health, especially when accomplished and maintained by personal choice and action, including proper diet, exercise, and health habits.

- 2. **Section 2.6.1.3 shall be amended by deleting and replacing the “SERVICE”/”BENEFIT LIMIT” for Dental Services as follows:**

Dental Services	<p>Dental Services shall be provided by the Dental Benefits Manager or in some cases, through an HCBS waiver program for persons with intellectual disabilities (i.e., mental retardation).</p> <p>However, the facility, medical and anesthesia services related to the dental service that are not provided by a dentist or in a dentist’s office shall be covered services provided by the CONTRACTOR when the dental service is covered by the DBM or through an HCBS waiver program for persons with intellectual disabilities (i.e., mental retardation).</p>
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- 3. **Section 2.6.1.5 shall be amended by deleting the existing Section 2.6.1.5.3 and renumbering the remaining Section accordingly, including any references thereto.**
- 4. **The renumbered Section 2.6.1.5.3.1 shall be amended by adding the phrase “review all requests for short-term NF stays and shall” as follows:**

2.6.1.5.3.1 The CONTRACTOR shall review all requests for short-term NF stays and shall authorize and/or reimburse short-term NF stays for Group 2 and Group 3 members only when (1) the member is enrolled in CHOICES Group 2 or 3, as applicable, and receiving HCBS upon admission; (2) the member meets the nursing facility level of care in place at the time of admission; (3) the member’s stay in the facility is expected to be less than ninety (90) days; and (4) the member is expected to return to the community upon its conclusion. The CONTRACTOR shall monitor all short-term NF stays for Group 2 and Group 3 members and shall ensure that the member is transitioned from Group 2 or Group 3, as applicable, to Group 1 at any time a) it is determined that the stay will not be short-term or the member will not transition back to the community; and b) prior to exhausting the ninety (90)-day short-term NF benefit covered for CHOICES Group 2 and Group 3 members.



5. The renumbered Section 2.6.1.5.3.1.2 shall be deleted and replaced as follows:

2.6.1.5.3.1.2 The CONTRACTOR shall monitor, on an ongoing basis, members utilizing the short-term NF benefit, and shall submit to TENNCARE on a monthly basis a member-by-member status for each Group 2 and Group 3 member utilizing the short-term NF stay benefit, including but not limited to the name of each Group 2 and Group 3 member receiving short-term NF services, the NF in which s/he currently resides, the date of admission for short-term stay, the number of days of short-term NF stay utilized for this admission, and the anticipated date of discharge back to the community. For any member exceeding the ninety (90)-day limit on short-term NF stay, the CONTRACTOR shall include explanation regarding why the benefit limit has been exceeded, and specific actions the CONTRACTOR is taking to facilitate discharge to the community or transition to Group 1, as applicable, including the anticipated timeline.

6. Section 2.7.2.7 shall be deleted and replaced as follows:

2.7.2.7 Psychiatric Rehabilitation Services

The CONTRACTOR shall provide psychiatric rehabilitation services in accordance with the requirements in Attachment I. As described in Attachment I, the covered array of services available under psychiatric rehabilitation are psychosocial rehabilitation, supported employment, peer recovery services, family support services, illness management and recovery, and supported housing. An individual may receive one or more of these services and may receive different services from different providers.

7. Section 2.7.4.2.1 shall be deleted and replaced as follows:

2.7.4.2.1 The Annual Community Outreach Plan shall be written in accordance with guidance prepared by TENNCARE. It shall include, but is not limited to: all proposed community/health education events related to TENNderCare; all proposed community/health education events unrelated to TENNderCare; and a system approved by TENNCARE for not only documenting and evaluating their events within thirty (30) days of occurrence, but also reporting on their evaluations in the TENNderCare/EPSTDT Quarterly Reports. An Annual Evaluation of the Plan shall be due no later than ninety (90) days following the end of a calendar year in a format approved by TENNCARE. This evaluation must include an appraisal of the objectives in the Plan and an assessment of the events conducted in the previous year in a format approved by TENNCARE.

8. Section 2.7.6.2.10.2 shall be deleted and replaced as follows:

2.7.6.2.10.2 The CONTRACTOR shall participate in a minimum of five (5) interagency activities with representatives from state agencies or community-based organizations per quarter, to either educate them on services available through TCS or to develop outreach and educational initiatives. All of the agencies engaged shall be those who serve TennCare enrollees who are at risk of DCS custody or have special healthcare needs.



Amendment 33 (cont.)

9. **Section 2.8.2.1 shall be amended by adding a new Section 2.8.2.1.1 as follows and renumbering the existing Sections accordingly.**

2.8.2.1.1 The CONTRACTOR shall make reasonable attempts to assess member's health risk utilizing the appropriate common HRA approved by the Bureau and Population Health staff. The information collected from these mini assessments will be used to align individual members with appropriate intervention approaches and maximize the impact of the services provided.

10. **The renumbered Section 2.8.2.1.3.1 shall be deleted and replaced as follows:**

2.8.2.1.3.1 All members identified as Level 1, through predicative modeling, and not pregnant are eligible for the Health Risk Management Program. At a minimum, the CONTRACTOR shall enroll members with chronic diseases that are prevalent in a significant number of members, or members with other chronic diseases utilizing significant health resources in their regional population.

11. **The renumbered Section 2.8.2.1.3 shall be amended by adding a new Section 2.8.2.1.3.3 as follows:**

2.8.2.1.3.3 The CONTRACTOR shall place all level 2 members who cannot be contacted by the process referenced in Section 2.8.4.5.2 of this Contract, or chose not to enroll in a level 2 program, in Level 1 programs.

12. **The renumbered Section 2.8.2.1.4 shall be deleted and replaced as follows:**

2.8.2.1.4 **Level 2** – Members eligible to participate at this Level shall be determined by predictive modeling identifying the top three percent (3%) of members, excluding level 2 maternity members, to be most at risk for adverse health outcomes, and/or by referrals or health risk assessments.

13. **Section 2.8.4.6.1 shall be amended by deleting and replacing the reference to “Section 2.8.4.5.1” with “Section 2.8.4.5.2”.**

14. **Section 2.8.11.5 shall be deleted and replaced as follows:**

2.8.11.5 The CONTRACTOR shall submit, through the current secure system, a list in Comma Separated Value (CSV) format consisting of the name, ID, DOB, stratification or all risk levels and the corresponding dates of eligibility for the level and program assignments for all MCO members.

15. **Section 2.8.12 shall be deleted and replaced as follows:**

2.8.12 Special Projects

2.8.12.1 As appropriate, the CONTRACTOR's Population Health staff shall participate in a collaborative MCO/TennCare workgroup to evaluate the common standard new enrollee assessments and address innovative ways to improve member completion rates.



Amendment 33 (cont.)

2.8.12.2 The CONTRACTOR shall conduct at least two rapid cycle improvement projects annually. One rapid cycle improvement project shall address increasing member engagement rates in the High Risk opt in level of Population Health programs. The second rapid cycle engagement project shall address engaging members to make behavioral changes such as weight loss, or smoking cessation. The project plans are to be reported in the quarterly report before implementation. The projects should then be conducted with the results to be reported in the next Population Health Quarterly Report.

16. Sections 2.9.5 through 2.9.5.6 shall be deleted and replaced with “Left Blank Intentionally”

2.9.5 Left Blank Intentionally

17. Section 2.9.6.2.4.1 shall be deleted and replaced as follows:

2.9.6.2.4.1 For members enrolled in CHOICES Group 1, who are, upon CHOICES enrollment, receiving nursing facility services, the CONTRACTOR shall reimburse such services in accordance with the level of reimbursement for nursing facility services (Level I or Level II) approved by TENNCARE (see Section 2.14.1.15), except that the CONTRACTOR may reimburse a facility at the Level I per diem rate when such rate is billed by the facility and there is an approved LOC eligibility segment for such level of reimbursement. Reimbursement for such services shall be from the current provider as of the effective date of CHOICES enrollment. The CONTRACTOR shall not move members enrolled in CHOICES Group 1 who are, upon CHOICES enrollment, receiving nursing facility services, to another facility unless: (1) the member or his/her representative specifically requests to move, which shall be documented in the member’s file; (2) the member or his/her representative provides written consent to move based on quality or other concerns raised by the CONTRACTOR, which shall not include the nursing facility’s rate of reimbursement; or (3) the facility where the member is residing is not a contract provider. If the nursing facility is a non-contract provider, the CONTRACTOR shall (a) provide continuation of the services pending enrollment of the facility as a contract provider (except a facility excluded for a 2-year period when the facility has withdrawn from Medicaid participation); (b) provide continuation of the services pending facilitation of the member’s transition to a contract facility, subject to the member’s agreement with such transition; or (c) may continue to reimburse services from the non-contract nursing facility in accordance with TennCare rules and regulations.

18. Section 2.9.6.2.4.4 and 2.9.6.2.4.5 shall be deleted and replaced as follows:

2.9.6.2.4.4 For purposes of the CHOICES program, the CONTRACTOR may decide whether it will issue service authorizations for nursing facility services, or whether it will instead process claims for such services in accordance with the level of care (i.e., reimbursement, including the duration of such level of reimbursement) approved by TENNCARE (see Section 2.14.1.15), except that the CONTRACTOR may reimburse a facility at the Level I per diem rate when such rate is billed by the facility and there is an approved LOC eligibility segment for such level of reimbursement.

2.9.6.2.4.5 For CHOICES members approved by TENNCARE for Level II reimbursement of nursing facility services, the CONTRACTOR shall be responsible for monitoring the member’s continued need for Medicaid reimbursed skilled and/or rehabilitation services, promptly notifying TENNCARE when such skilled and/or rehabilitative services are no



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longer medically necessary, and for the submission of information needed by TENNCARE to reevaluate the member's level of care (i.e., reimbursement) for nursing facility services (see also Section 2.14.1.15).

19. Sections 2.9.6.2.5.1, 2.9.6.2.5.2, 2.9.6.2.5.3, and 2.9.6.2.5.10 shall be deleted and replaced as follows:

2.9.6.2.5.1 For members enrolled in CHOICES Group 2 who are, upon CHOICES enrollment, receiving community-based residential alternative services that are covered in CHOICES, the CONTRACTOR shall, immediately upon notice of the member's enrollment in CHOICES, authorize such services from the current provider as of the effective date of CHOICES enrollment. The CONTRACTOR shall not transition members enrolled in CHOICES Group 2 who are, upon CHOICES enrollment, receiving services in a community-based residential alternative setting to another facility unless: (1) the member or his/her representative specifically requests to move, which shall be documented in the member's file; (2) the member or his/her representative provides written consent to move based on quality or other concerns raised by the CONTRACTOR; or (3) the facility where the member is residing is not a contract provider; if the facility is a non-contract provider, the CONTRACTOR shall authorize medically necessary services from the non-contract provider for at least thirty (30) days which shall be extended as necessary to ensure continuity of care pending the facility's enrollment with the CONTRACTOR or the member's transition to a contract provider.

2.9.6.2.5.2 For members in CHOICES Group 2 who upon CHOICES enrollment are receiving services in a community-based residential alternative setting, within ten (10) business days of notice of the member's enrollment in CHOICES the care coordinator shall conduct a face-to-face visit with the member, perform a comprehensive needs assessment (see Section 2.9.6.5), develop a plan of care (see Section 2.9.6.6), and authorize and initiate additional CHOICES HCBS specified in the plan of care (i.e., assistive technology)..

2.9.6.2.5.3 The care coordinator shall, for all other CHOICES members in Groups 2 and 3 not specified in 2.9.6.2.5.1 – 2.9.6.2.5.2 above, within ten (10) business days of notice of the member's enrollment in CHOICES, conduct a face-to-face visit with the member, perform a comprehensive needs assessment (see Section 2.9.6.5), develop a plan of care (see Section 2.9.6.6), and authorize and initiate CHOICES HCBS.

2.9.6.2.5.10 As part of the face-to-face visit for members in CHOICES Group 2 or Group 3, the care coordinator shall review, and revise as necessary, the member's risk assessment, and develop a risk agreement, which shall document identified risks to the member, the consequences of such risks, strategies to mitigate the identified risks, and the member's decision regarding his/her acceptance of risk. The risk agreement shall be signed and dated by the member and shall also be signed by the care coordinator, attesting that such risks and strategies have been discussed with the member or his/her representative prior to their decision to accept such risk.

20. Section 2.9.6.3.9 shall be amended by deleting and replacing the references to "DHS" with "TENNCARE".



21. Sections 2.9.6.3.20.1, 2.9.6.3.20.2, and 2.9.6.3.20.3 shall be deleted and replaced as follows:

- 2.9.6.3.20.1 For purposes of the CHOICES program, service authorizations for CHOICES HCBS shall include the amount, frequency, and duration of each service to be provided, and the schedule at which such care is needed, as applicable; and other relevant information as prescribed by TENNCARE. The CONTRACTOR may determine the duration of time for which CHOICES HCBS will be authorized. However, the CONTRACTOR shall be responsible for monitoring its authorizations and for ensuring that there are no gaps in authorizations for CHOICES HCBS in accordance with the plan of care. The CONTRACTOR shall further be responsible for ensuring that service authorizations are consistent with the plan of care, including the schedule at which services are needed and any updates to the plan of care and/or schedule, and except in the following circumstance, for notifying providers in advance when a service authorization (including a schedule) will be changed. Retroactive entry or adjustments in service authorizations for CHOICES HCBS should be made only when required to accommodate payment of services that had been authorized but an adjustment in the schedule of services was required based on the member's needs.
- 2.9.6.3.20.2 Notwithstanding the address and/or phone number in the 834 file, for purposes of the EVV system (see Section 2.9.6.12.5.), the CONTRACTOR shall use the member's address or phone number or appropriate alternative phone number as confirmed during the intake visit (see Section 2.9.6.3.9.) and updated (as applicable) during subsequent care coordination contacts (see Section 2.9.6.9.2.1.5), through EVV alert monitoring or other member contacts for all HCBS that will be logged into the EVV system.
- 2.9.6.3.20.3 The CONTRACTOR may decide whether it will issue service authorizations for nursing facility services, or whether it will instead process claims for such services in accordance with the level of care and/or reimbursement (including the duration of such level of care and/or reimbursement) approved by TENNCARE (see Section 2.14.1.15), except that the CONTRACTOR may reimburse a facility at the Level I per diem rate when such rate is billed by the facility and there is an approved LOC eligibility segment for such level of reimbursement. If the CONTRACTOR elects to authorize nursing facility services, the CONTRACTOR may determine the duration of time for which nursing facility services will be authorized. However, the CONTRACTOR shall be responsible for monitoring its authorizations and for ensuring that there are no gaps in authorizations for CHOICES nursing facility services in accordance with the level of care and/or reimbursement approved by TENNCARE. Retroactive entry or adjustments in service authorizations for nursing facility services should be made only upon notification of retroactive enrollment into or disenrollment from CHOICES Group 1a or 1b via the outbound 834 file from TENNCARE.

22. Section 2.9.6.5.1.1 shall be amended by adding the words "overall wellness" as follows:

- 2.9.6.5.1.1 As part of the face-to-face intake visit for current members or face-to-face visit with new members in CHOICES Group 1, as applicable, a care coordinator shall conduct any needs assessment deemed necessary by the CONTRACTOR, using a tool prior approved by TENNCARE and in accordance with protocols specified by TENNCARE. This assessment may include identification of targeted strategies related to improving overall wellness, health, functional, or quality of life outcomes (e.g., related to Population Health or pharmacy management) or to increasing and/or maintaining functional abilities,



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including services covered by the CONTRACTOR that are beyond the scope of the nursing facility services benefit. The care coordinator shall ensure coordination of the member's physical health, behavioral health, and long-term care needs and shall assess at least annually the member's potential for an interest in transition to the community. For children under the age of 21 in nursing facilities, this shall include explanation to the member or his parent or authorized representative, as applicable, of benefits available pursuant to EPSDT, including medically necessary benefits such as home health or private duty nursing that may be provided in the community as an alternative to nursing facility care.

23. Section 2.9.6.5.2.2 shall be deleted and replaced as follows:

2.9.6.5.2.2 At a minimum, for members in CHOICES Group 2 and 3, the comprehensive needs assessment shall assess: (1) the member's overall wellness including physical, behavioral, functional, and psychosocial needs, and an evaluation of the member's financial health as it relates to the member's ability to maintain a safe and healthy living environment; (2) the member's natural supports, including care being provided by family members and/or other caregivers, and long-term care services the member is currently receiving (regardless of payor), and whether there is any anticipated change in the member's need for such care or services or the availability of such care or services from the current caregiver or payor; and (3) the physical health, behavioral health, and long-term care services and other social support services and assistance (e.g., housing or income assistance) that are needed, as applicable, to ensure the member's health safety and welfare in the community and to delay or prevent the need for institutional placement.

24. Section 2.9.6.5.2.4 shall be amended by adding a new Section 2.9.6.5.2.4.1 as follows:

2.9.6.5.2.4.1 For CHOICES Group 3 members whose change in needs result in a transition to Group 2, the CONTRACTOR shall request the transition by submitting a PAE to TENNCARE and upon receiving approval for the member's enrollment into Group 2, ensure that any new service(s) specified in the plan of care are initiated within five (5) business days, except when such service(s) may be initiated only upon completion of an adverse action pertaining to another service such that advance notice is required. In such case, the new service(s) shall be initiated upon expiration of the advance notice period or upon resolution of any timely filed appeal requiring continuation of the existing benefits.

25. Section 2.9.6.6.1.1 shall be amended by adding the words "overall wellness," as follows:

2.9.6.6.1.1 For members in CHOICES Group 1, the member's care coordinator may: (1) rely on the plan of care developed by the nursing facility for service delivery instead of developing a plan of care for the member; and (2) supplement the nursing facility plan of care as necessary with the development and implementation of targeted strategies to improve overall wellness, health, functional, or quality of life outcomes (e.g., related to Population Health or pharmacy management) or to increase and/or maintain functional abilities. A copy of any supplements to the nursing facility plan of care, and updates to such supplements, shall be maintained by the CONTRACTOR in the member's CHOICES file.



26. Section 2.9.6.6.2.4 shall be deleted and replaced as follows:

2.9.6.6.2.4 The plan of care developed for CHOICES members in Groups 2 and 3 prior to initiation of CHOICES HCBS shall at a minimum include: (1) pertinent demographic information regarding the member including the member's current address and phone number(s), the name and contact information of any representative and a list of other persons authorized by the member to have access to health care (including long-term care) related information and to assist with assessment, planning, and/or implementation of health care (including long-term care) related services and supports; (2) care, including specific tasks and functions, that will be performed by family members and other caregivers; (3) home health, private duty nursing, and long-term care services the member will receive from other payor sources including the payor of such services; (4) home health and private duty nursing that will be authorized by the CONTRACTOR; (5) CHOICES HCBS that will be authorized by the CONTRACTOR, including the amount, frequency, duration, and scope (tasks and functions to be performed) of each service to be provided, the schedule at which such care is needed, and the address or phone number(s) that will be used to log visits into the EVV system, as applicable; (6) a detailed back-up plan for situations when regularly scheduled HCBS providers are unavailable or do not arrive as scheduled; the back-up plan may include paid and unpaid supports and shall include the names and telephone numbers of persons and agencies to contact and the services provided by listed contacts; the CONTRACTOR shall assess the adequacy of the back-up plan; and (7) for CHOICES Group 2 members, the projected TennCare monthly and annual cost of home health and private duty nursing identified in (4) above, and the projected monthly and annual cost of CHOICES HCBS specified in (5) above, and for CHOICES Group 3 members, the projected total cost of CHOICES HCBS specified in (5) above, excluding the cost of minor home modifications.

27. Section 2.9.6.6.2.5.1 shall be amended by adding the words "overall wellness," as follows:

2.9.6.6.2.5.1 Description of the member's overall wellness, current physical and behavioral health conditions and functional status (i.e., areas of functional deficit), and the member's physical, behavioral and functional needs;

28. Section 2.9.6.6.2.5.6 shall be amended by adding the word "wellness," as follows:

2.9.6.6.2.5.6 A person-centered statement of goals, objectives and desired wellness, health, functional and quality of life outcomes for the member and how CHOICES services are intended to help the member achieve these goals;

29. Section 2.9.6.6.2.6.4 shall be deleted and replaced as follows:

2.9.6.6.2.6.4 Instances in which a member's signature is not required are limited to: 1) member-initiated schedule changes to the POC that do not alter the level of services (i.e. the amount, duration or type of services) detailed in the current POC for the member; 2) changes in the provider agency that will deliver services that do not alter the level of services (i.e. the amount, duration or type of services) detailed in the current POC for the member; however, all schedule changes must be member-initiated; 3) changes in the member's current address and phone number(s) or the phone number(s) that will be used to log visits into the EVV system; 4) the end of a member's participation in MFP at the



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conclusion of his 365-day participation period; or 5) instances as permitted pursuant to TennCare policies and protocols. Documentation of such changes shall be maintained in the member's records.

30. Sections 2.9.6.6.2.8 and 2.9.6.6.2.8.1 shall be deleted and replaced as follows:

2.9.6.6.2.8 Within five (5) business days of completing a reassessment of a member's needs, the member's care coordinator shall update the member's plan of care as appropriate, and the CONTRACTOR shall authorize and initiate CHOICES HCBS in the updated plan of care, except when such service(s) may be initiated only upon completion of an adverse action such that advance notice is required. In such case, HCBS in the updated plan of care shall be initiated upon expiration of the advance notice period or upon resolution of any timely filed appeal requiring continuation of the existing benefits. The CONTRACTOR shall comply with requirements for service authorization in Section 2.9.6.2.5.12, change of provider in Section 2.9.6.2.5.13, and notice of service delay in Section 2.9.6.2.5.14.

2.9.6.6.2.8.1 Within three (3) business days of updating the member's plan of care, the member's care coordinator/care coordination team shall provide a copy of all relevant changes to the FEA, as applicable, and to other providers authorized to deliver care to the member. Relevant information shall include any information needed to ensure the provision of quality care for the member and to help ensure the member's health, safety, and welfare, including but not limited to any changes in the tasks and functions to be performed.

31. Section 2.9.6.6.2.9 shall be deleted and replaced as follows:

2.9.6.6.2.9 The member's care coordinator shall inform each member of his/her eligibility end date and educate members regarding the importance of maintaining TennCare CHOICES eligibility, that eligibility must be redetermined at least once a year, and that members receiving CHOICES HCBS may be contacted by TENNCARE or its designee to offer assistance with the redetermination process (e.g., collecting appropriate documentation and completing the necessary forms), when such process has not been completed timely and the member is at risk of losing eligibility.

32. Section 2.9.6.8.26 shall be amended by deleting the phrase "(e.g., DHS)".

33. Section 2.9.6.8.26.2 shall be deleted and replaced as follows:

2.9.6.8.26.2 The CONTRACTOR shall, in a manner prescribed by TENNCARE notify: a) TENNCARE of all NF discharges and elections of hospice services in a NF and of all NF discharges and transfers between NFs; and b) receiving NFs of all applicable level of care information when a member is transferring between NFs.

34. Section 2.9.6.9.1.1.5 shall be amended by deleting and replacing the word "DHS" with "TENNCARE".



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35. Section 2.9.6.9.1.1 shall be amended by adding a new Section 2.9.6.9.1.1.7 as follows:

2.9.6.9.1.1.7 Develop protocols and processes for care coordinators to escalate and report as appropriate concerns regarding NF quality.

36. Section 2.9.6.9.2.1.5 shall be deleted and replaced as follows:

2.9.6.9.2.1.5 Document and confirm the applicant's current address and phone number(s) or appropriate alternative phone number(s) that the member's service provider will use to log visits into the EVV system, and assist the member in updating his or her address with TENNCARE or the Social Security Administration, if applicable.

37. Section 2.9.6.9.2.1.17.2 shall be deleted and replaced as follows:

2.9.6.9.2.1.17.2 Significant change in health and/or functional status, including any change that results in the member's level of care and transition between CHOICES Groups, e.g., transitions from Group 2 to Group 3 or Group 3 to Group 2;

38. Section 2.9.6.9.2.1 shall be amended by adding a new Section 2.9.6.9.2.1.18 as follows and renumbering the existing Section accordingly including any references thereto.

2.9.6.9.2.1.18 When, due to a change in circumstances, a member is approved for transition from Group 2 to Group 3 or from Group 3 to Group 2, within five (5) business days of scheduled initiation of new or modified CHOICES HCBS in the updated plan of care, the member's care coordinator/care coordination team shall contact members in CHOICES Groups 2 and 3 to confirm that new or modified services are being provided in accordance with the plan of care, and that the member's needs are being met (such initial contact may be conducted by phone).

39. Section 2.9.6.9.3.1 shall be amended by adding new Sections 2.9.6.9.3.1.2 and 2.9.6.9.3.1.7 as follows and renumbering the remaining Sections accordingly including any references thereto.

2.9.6.9.3.1.2 Track and monitor all members whose LOC eligibility has an expiration date and ensure that a LOC reassessment (i.e., PAE) is completed and submitted to TENNCARE at least eight (8) business days prior to expiration of the member's current LOC eligibility segment, including all required supporting documentation needed to appropriately determine the member's LOC eligibility going forward.

2.9.6.9.3.1.7 Assist members in establishing and achieving personal wellness goals.



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40. The renumbered Section 2.9.6.9.3.1.11 shall be deleted and replaced as follows:

2.9.6.9.3.1.11 When the CONTRACTOR is facilitating a member's admission to a nursing facility, ensure that all PASRR requirements have been met prior to the member's admission to a nursing facility, including a PASRR level I screening and as applicable, a level II PASRR evaluation, whether the screening is completed by the nursing facility, the CONTRACTOR, or another entity.

2.9.6.9.3.1.11.1 The CONTRACTOR shall coordinate with the nursing facility to help ensure that current information regarding the member's mental health or intellectual disabilities needs (as available) is reflected in the PASRR screening in order to support an appropriate PASRR determination.

41. Section 2.9.6.9.4.3.5 shall be amended by adding a new Section 2.9.6.9.4.3.5.1 as follows:

2.9.6.9.4.3.5.1 When a member is approved for transition from Group 2 to Group 3 or from Group 3 to Group 2, within five (5) business days of scheduled initiation of new or modified CHOICES HCBS in the updated plan of care, the member's care coordinator/care coordination team shall contact members in CHOICES Groups 2 and 3 to confirm that new or modified services are being provided in accordance with the plan of care, and that the member's needs are being met (such initial contact may be conducted by phone).

42. Section 2.9.6.9.4.3.9 shall be amended by deleted the phrase "or Group 3" so that the amended Section reads as follows:

2.9.6.9.4.3.9 Members in CHOICES Group 2 participating in MFP shall, for at least the first ninety (90) days following transition to the community, be visited in their residence face-to-face by their care coordinator at least monthly with an interval of at least fourteen (14) days between contacts to ensure that the plan of care is being followed, that the plan of care continues to meet the member's needs, and the member has successfully transitioned back to the community. Thereafter, for the remainder of the member's MFP participation period, minimum contacts shall be as described in 2.9.6.9.4.3.7 unless more frequent contacts are required based on the member's needs and circumstances and as reflected in the member's plan of care, or based on a significant change in circumstances (see Sections 2.9.6.9.2.1.17. and 2.9.8.4.5) or a short-term nursing facility stay (see Sections 2.9.8.8.5 and 2.9.8.8.7).

43. Section 2.9.6.10.3.3 shall be amended by adding the phrase "or Group 3, as applicable" at the end of the existing text.

2.9.6.10.3.3 If eligible CHOICES HCBS are not initiated within sixty (60) days following referral to the FEA, the CONTRACTOR shall notify the member that eligible CHOICES HCBS must be initiated by contract providers unless these HCBS are not needed on an ongoing basis in order to safely meet the member's needs in the community, in which case, the CONTRACTOR shall submit documentation to TENNCARE to begin the process of disenrollment from CHOICES Group 2 or Group 3, as applicable.



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44. Section 2.9.6.10.5 shall be amended by adding a new Section 2.9.6.10.5.1 as follows:

2.9.6.10.5.1 The member or member's representative must retain authority and responsibility for consumer direction.

45. Sections 2.9.6.10.7 through 2.9.10.6.13 shall be deleted and replaced as follows:

2.9.6.10.7 For members electing to participate in consumer direction, the member's care coordinator shall integrate the member's back-up plan for consumer-directed workers (including any updates thereto) into the member's back-up plan for services provided by contract providers, as applicable, and the member's plan of care. The care coordinator shall review the back-up plan developed by the member or his/her representative (as applicable) for consumer direction to determine its adequacy to address the member's needs. The care coordinator shall assist the member in implementing the back-up plan as needed, and shall monitor for late and missed visits and to ensure that the back-up plan was implemented timely and that the member's needs are being met.

2.9.6.10.8 For members electing to participate in consumer direction, the member's care coordinator shall reassess the adequacy of the member's back-up plan for consumer direction on at least an annual basis or as frequently as needed, which shall include any time there are changes in the type, amount, duration, scope of eligible CHOICES HCBS or the schedule at which such services are needed, changes in consumer-directed workers (when such workers also serve as a back-up to other workers) or changes in the availability of paid or unpaid back-up workers to deliver needed care.

2.9.6.10.9 For members electing to participate in consumer direction, the member's care coordinator shall develop and/or update risk agreement which takes into account the member's decision to participate in consumer direction, and which identifies any additional risks associated with the member's decision to direct his/her services, the potential consequences of such risk, as well as measures to mitigate these risks. The member's representative (if applicable) shall participate in the risk assessment process. The new or updated risk agreement, shall be signed by the member (or the member's representative, as applicable) and the care coordinator. The CONTRACTOR shall provide a copy of the risk agreement to the member/representative and the FEA.

2.9.6.10.10 On an ongoing basis, the CONTRACTOR shall ensure that needs reassessments and updates to the plan of care occur per requirements specified in Sections 2.9.6.9 of this Contract. The care coordinator shall ensure that, for members participating in consumer direction, the FEA is invited to participate in these meetings as appropriate.

2.9.6.10.11 Within three (3) business days of updating the member's plan of care (see Section 2.9.6.6.2.8.1), the member's care coordinator/care coordination team shall provide a copy of all relevant changes to the FEA (see Section 2.9.6.6.2.8.1. of this Contract).



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- 2.9.6.10.12 Within two (2) business days of receipt of the notification from the FEA indicating that all requirements have been fulfilled and the date that the consumer direction can begin for a member, the CONTRACTOR shall forward to the FEA an authorization for consumer directed services for that member. Each authorization for consumer directed services shall include authorized service, authorized units of service, including amount, frequency and duration and the schedule at which services are needed, start and end dates, and service code(s).
- 2.9.6.10.13 The member's care coordinator/care coordination team shall work with and coordinate with the FEA in implementing consumer direction of eligible CHOICES HCBS (see Section 2.9.7.3.4).
46. **Section 2.9.6.10 shall be amended by adding a new Section 2.9.6.10.14 as follows and renumbering the remaining Section accordingly, including any references thereto.**
- 2.9.6.10.14 The member's care coordinator shall monitor consumer direction of eligible CHOICES HCBS.
47. **The renumbered Section 2.9.6.10.17 shall be deleted and replaced as follows:**
- 2.9.6.10.17 If at any time abuse or neglect is suspected, the member's care coordinator or the FEA shall report the allegations to the CONTRACTOR within 24 hours in accordance with the CONTRACTOR's abuse and neglect plan protocols. The notification shall include at a minimum: the member name; date of allegation reported and/or identified; description of issue; measures taken to mitigate risk; status of reporting to CPS or APS, as appropriate. If the allegation is in reference to a worker or representative, the FEA shall contact the member/representative to immediately release the worker or representative from his/her duties until the investigation is complete. The FEA shall notify the CONTRACTOR regarding this communication with the member/representative and the member or representative's decision. The care coordinator shall work with the member to find a new representative and the FEA shall work with the member to find a suitable replacement worker, if applicable. If the allegations are substantiated as a result of the investigation, the representative or worker shall no longer be allowed to participate in the CHOICES program as a representative or worker. If the investigation is inconclusive, the member may elect to retain the worker or representative. The member's care coordinator, with assistance from the FEA as appropriate, shall make any updates to the member's plan of care and/or risk assessment/risk agreement deemed necessary to help ensure the member's health and safety, and shall provide, at least annually, education of the member and his/her representative of the risk of, and signs and symptoms of, abuse and neglect. The CONTRACTOR may initiate action to involuntary disenroll the member from consumer direction at any time the CONTRACTOR feels that the member's decisions or actions constitute unreasonable risk such that the member's needs can no longer be safely and effectively met in the community while participating in consumer direction.



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48. Section 2.9.6.11.18.1 shall be deleted and replaced as follows:

2.9.6.11.18.1 The CHOICES program including a description of the CHOICES groups; eligibility for CHOICES enrollment; enrollment in CHOICES; enrollment targets for Groups 2 and 3 (excluding Interim Group 3), including reserve capacity and administration of waiting lists; and CHOICES benefits, including benefit limits, the individual cost neutrality cap for Group 2, and the expenditure cap for Group 3;

49. Section 2.9.6.12.7 shall be deleted and replaced as follows:

2.9.6.12.7 Notwithstanding the address and/or phone number in the 834 file, the CONTRACTOR shall use the member's address or phone number or appropriate alternative phone number, as confirmed during the intake visit (see Section 2.9.6.3.9.) and updated (as applicable) during subsequent care coordination contacts (see Section 2.9.6.9.2.1.5.) for all HCBS that will be logged into the EVV system.

50. Section 2.9.7.1.1 shall be amended by adding the phrase "in Group 2" to the second sentence as follows:

2.9.7.1.1 The CONTRACTOR shall offer consumer direction of eligible CHOICES HCBS to all CHOICES Group 2 and 3 members who are determined by a care coordinator, through the needs assessment/reassessment process, to need attendant care, personal care, in-home respite, companion care services and/or any other service specified in TennCare rules and regulations as available for consumer direction. (Companion care is only available for persons in Group 2 electing consumer direction of eligible CHOICES HCBS.) A service that is not specified in TennCare rules and regulations as available for consumer direction or that is not a CHOICES HCBS shall not be consumer directed. Consumer direction in CHOICES affords members the opportunity to have choice and control over how eligible CHOICES HCBS are provided, who provides the services and how much workers are paid for providing care, up to a specified maximum amount established by TENNCARE (see Section 2.9.7.6.11). Member participation in consumer direction of eligible CHOICES HCBS is voluntary. Members may elect to participate in or withdraw from consumer direction of eligible CHOICES HCBS at any time, service by service, without affecting their enrollment in CHOICES. To the extent possible, the member shall provide his/her care coordinator ten (10) days advance notice regarding his/her intent to no longer direct one or more eligible CHOICES HCBS or to withdraw from participation in consumer direction of eligible CHOICES HCBS entirely. The CONTRACTOR shall respond to the member's request in keeping with the timeframes and processes set forth in this Section, in order to facilitate a seamless transition to appropriate service delivery. TENNCARE may establish reasonable limitations on the frequency with which members may opt into and out of consumer direction of eligible CHOICES HCBS.

51. The title of Section 2.9.7.2 shall be amended to say "Representative for Consumer Direction".



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52. Section 2.9.7.2.6 shall be deleted and replaced as follows:

2.9.7.2.6 A member may change his/her representative at any time. The member shall immediately notify his/her care coordinator and the FEA when he/she intends to change representatives. The care coordinator shall verify that the new representative meets the qualifications as described above. A new representative agreement shall be completed and signed, in the presence of a care coordinator, prior to the new representative assuming their respective responsibilities. The care coordinator shall immediately notify the FEA in writing when a member changes his/her representative and provide a copy of the representative agreement. The CONTRACTOR shall facilitate a seamless transition to the new representative, and ensure that there are no interruptions or gaps in services. As part of the needs assessment and plan of care process, the care coordinator shall educate the member about the importance of notifying the care coordinator prior to changing a representative.

53. Sections 2.9.7.3.2.1 and 2.9.7.3.2.2 shall be deleted and replaced as follows:

2.9.7.3.2.1 Assign a supports broker to each CHOICES member electing to participate in consumer direction of eligible CHOICES HCBS. The supports broker shall be responsible for assisting the member with enrollment into consumer direction and with the enrollment of new workers;

2.9.7.3.2.2 Notify the member's care coordinator upon becoming aware of any additional risk associated with the member participating in consumer direction that may need to be addressed in the risk assessment and plan of care processes;

54. Sections 2.9.7.3.2.9 shall be deleted and replaced as follows:

2.9.7.3.2.9 Develop and implement a process to support members or their representatives in ensuring that consumer directed workers maintain in the member's home (or alternative location or format approved by TENNCARE) documentation of service delivery to support payments for services provided through consumer direction, and periodically monitor such documentation;

55. Section 2.9.7.3.2.12 shall be amended by adding the word "and" to the end of the paragraph, the existing Section 2.9.7.3.2.13 shall be deleted in its entirety and the renumbered Section 2.9.7.3.2.13 shall be deleted and replaced as follows. All references shall be updated accordingly.

2.9.7.3.2.13 Notify the CONTRACTOR within no more than twenty-four (24) hours of identification of critical incidents (see Section 2.15.7).

56. Section 2.9.7.3.3.1 through 2.9.7.3.3.6 shall be deleted and replaced as follows:

2.9.7.3.3.1 As needed, assist the member and/or representative in developing job descriptions;

2.9.7.3.3.2 As needed, assist the member and/or representative in locating and recruiting workers;



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- 2.9.7.3.3.3 As needed, assist the member and/or representative in interviewing workers (developing questions, evaluating responses);
- 2.9.7.3.3.4 Assist the member and/or representative in developing (as part of the onboarding process for new workers) a schedule for the member's workers that comports with the schedule at which services are needed by the member as reflected in the plan of care;
- 2.9.7.3.3.5 Assist the member and/or representative in managing and monitoring payments to workers; and
- 2.9.7.3.3.6 Assist the member/representative in identification and training of new workers, as needed.

57. Section 2.9.7.3.4 shall be deleted and replaced as follows:

- 2.9.7.3.4 The CONTRACTOR's care coordination functions shall not duplicate the supports brokerage functions performed by the FEA or its subcontractor. A member's care coordinator shall be responsible for monitoring the member's services through consumer direction.

58. Section 2.9.7.4.5 and 2.9.7.4.7 shall be deleted and replaced as follows:

- 2.9.7.4.5 The care coordinator shall determine if the member will appoint a representative to assume the consumer direction functions on his/her behalf. If the member does not intend to appoint a representative, the care coordinator shall determine the extent to which a member requires assistance to participate in consumer direction of eligible CHOICES HCBS, based upon the results of the member's responses to the self-assessment instrument developed by TENNCARE. The self-assessment instrument shall be completed by the member with assistance from the member's care coordinator as appropriate. The care coordinator shall file the completed self-assessment in the member's file and provide a copy to the FEA.
- 2.9.7.4.7 Within two (2) business days of signing the representative agreement or completion of the self-assessment instrument if the member has not designated a representative and the care coordinator determines that the member does not require a representative to assist the member in directing his/her care, the CONTRACTOR shall forward to the FEA a referral initiating the member's participation in consumer direction of eligible CHOICES HCBS. The referral shall include at a minimum: the date of the referral; the member's name, address, telephone number, and social security number (SSN); the name of the representative and telephone number (if applicable); member's MCO ID number; member's CHOICES enrollment date; eligible selected HCBS, including amount, frequency and duration of each by type; and care coordinator's name and contact information. The CONTRACTOR shall also forward to the FEA a copy of the written confirmation of the member's decision to participate in consumer direction of eligible CHOICES HCBS, the signed POC, and the representative agreement, if applicable. Referrals shall be submitted electronically on a daily basis using the agreed upon data interface (either a standard electronic file transfer or the FEA's web portal technology or both) and process. Referrals shall be submitted on a member-by-member basis.



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59. Sections 2.9.7.4.10.1, 2.9.7.4.10.4, 2.9.7.4.10.6, 2.9.7.4.10.7, 2.9.7.4.10.10, 2.9.7.4.10.11, and 2.9.7.4.10.13 shall be deleted and replaced as follows:

- 2.9.7.4.10.1 The member/representative (as applicable) shall have primary responsibility for the development and implementation of the back-up plan for consumer directed services. The FEA shall assist the member/representative as needed in developing and verifying the initial back-up plan for consumer direction that adequately identifies how the member/representative will address situations when a scheduled worker is not available or fails to show up as scheduled. The care coordinator shall assist the member as needed with implementing the back-up plan and shall update and verify the back-up plan annually and as needed.
- 2.9.7.4.10.4 All persons and/or organizations noted in the back-up plan for consumer direction shall be contacted by the member/representative to determine their willingness and availability to serve as back-up contacts. For the initial back-up plan, the FEA shall confirm with these persons and/or organizations their willingness and availability to provide care when needed, document confirmation in the member's file and forward a copy of the documentation to the CONTRACTOR. The care coordinator shall be responsible for updating and verifying the back-up plan on an ongoing basis.
- 2.9.7.4.10.6 The care coordinator shall assist the member or his/her representative (as applicable) in implementing the back-up plan for consumer direction as needed, monitor to ensure that the back-up plan is implemented and effectively working to meet the member's needs, and immediately address any concerns with the back-up plan or the member's care.
- 2.9.7.4.10.7 The care coordinator shall assist the member or his/her representative (as applicable) in reviewing and updating the back-up plan for consumer direction at least annually and as frequently as necessary, which shall include any time there are changes in the type, amount, duration, scope of eligible CHOICES HCBS or the schedule at which such services are needed, changes in workers (when such workers also serve as a back-up to other workers) and changes in the availability of paid or unpaid back-up workers to deliver needed care. As part of the annual review of the back-up plan, the member or his/her representative and the care coordinator shall confirm that each person specified in the back-up plan continues to be willing and available to serve as back-up workers to deliver needed care and to perform the tasks and functions needed by the member. Any updates to the back-up plan for consumer direction shall be provided to the FEA.
- 2.9.7.4.10.10 The care coordinator shall develop and/or update risk agreement which takes into account the member's decision to participate in consumer direction, and which identifies any additional risks associated with the member's decision to direct his/her services, the potential consequences of such risks, as well as measures to mitigate these risks. The member/representative shall participate in the process. The member's representative (if applicable) shall participate in the risk assessment process. The new or updated risk agreement shall be signed by the member or his/her representative (as applicable) and by the care coordinator. The CONTRACTOR, member/representative and FEA shall receive a copy of the risk agreement. The CONTRACTOR and the FEA shall each file a copy of the risk agreement in the member's file.



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2.9.7.4.10.11 The FEA shall notify the member's care coordinator immediately if they become aware of changes in the member's needs and/or circumstances which warrant a reassessment of needs and/or risk, or changes to the plan of care or risk agreement.

2.9.7.4.10.13 On an ongoing basis, the CONTRACTOR shall ensure that needs reassessments and updates to the plan of care occur per requirements specified in Sections 2.9.6.9 of this Contract. The care coordinator shall ensure that the FEA is invited to participate in these meetings as appropriate.

60. Sections 2.9.7.5.5 and 2.9.7.5.8 shall be deleted and replaced as follows:

2.9.7.5.5 On a weekly basis the FEA shall update the member's care coordinator of the status of completing required functions necessary to initiate consumer direction, including obtaining completed paperwork from the member/representative and obtaining workers for each identified consumer directed service and any anticipated timeframes by which qualified workers shall be secured and consumer directed services may begin.

2.9.7.5.8 Upon the scheduled start date of consumer directed services, the member's care coordinator/care coordination team shall begin monitoring to ensure that services have been initiated and continue to be provided as authorized. This shall include ongoing monitoring via electronic visit verification to ensure that services are provided in accordance with the member's plan of care, including the amount, frequency, duration and scope of each service, in accordance with the member's service schedule. Upon the identification of any gaps in care, the member's care coordinator/care coordination team shall assist the member or his/her representative as needed in implementing the member's back-up plan for consumer direction.

61. Section 2.9.7.6.1.1 shall be deleted and replaced as follows:

2.9.7.6.1.1 A member cannot waive a background check for a potential worker. A background check may reveal a potential worker's past criminal conduct that may pose an unacceptable risk to the member. The following findings may place the member at risk and may result in a potential worker failing the background check, possibly disqualifying a person from serving as a worker:



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62. Section 2.9.7.6.1.2 through 2.9.7.6.1.2.5 shall be deleted and replaced and Section 2.9.7.6.1 shall be amended by adding a new Sections 2.9.7.6.1.3, and 2.9.7.6.1.4 and 2.9.7.6.1.4.1 as follows:

- 2.9.7.6.1.2 If a potential worker fails the background check, the potential worker may request an individualized assessment that will be conducted by the member with the help of the FEA. The individualized assessment process will help determine whether the potential worker may be excluded because of past criminal conduct. The individualized assessment will provide the potential worker with notice that he/she has been screened out because of criminal conduct and provide an opportunity for the potential worker to explain why the exclusion should not be applied to his/her circumstances. The member, with the assistance of the FEA will consider the following factors:
- 2.9.7.6.1.2.1 Whether or not the evidence gathered during the potential worker's individualized assessment shows that the criminal conduct is related to the job in such a way that could place the member at-risk;
 - 2.9.7.6.1.2.2 The nature and gravity of the offense or conduct, such as whether the offense is related to physical or sexual or emotional abuse of another person, if the offense involves violence against another person or the manufacture, sale or distribution of drugs; and
 - 2.9.7.6.1.2.3 The time that has passed since the offense or conduct and/or completion of the sentence.
- 2.9.7.6.1.3 After considering the individualized assessment and any other evidence submitted by the potential worker, the member can decide not to hire the potential worker or may request from TENNCARE an exception to the potential worker's possible disqualification.
- 2.9.7.6.1.4 If a member decides to request an exception to the possible disqualification of the potential worker, the FEA shall assist the member in completing the exception request Form and submitting the potential worker's individualized assessment to TENNCARE. TENNCARE shall review the exception request and determine whether or not the potential worker's possible exclusion from employment would be job related and consistent with business necessity (i.e. the exclusion effectively links specific criminal conduct and its dangers with the risks inherent in the duties of a particular position), the nature and gravity of the criminal conduct, and the time that has passed since the criminal conduct and or the completion of the sentence, and that applicable federal and state laws do not prohibit the hiring of persons convicted of the criminal conduct in question.
- 2.9.7.6.1.4.1 TENNCARE approved exceptions to a potential worker's disqualification shall only be effective for a maximum of one (1) year from the approval date and may be revoked if the member is at-risk. The member is responsible for requesting a renewal of the worker's exception to disqualification and the FEA shall assist the member with that request. Renewals shall follow the exception to disqualification process outlined in Section 2.9.7.6.1.4.



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63. Section 2.9.7.7.2 shall be amended by adding a new Section 2.9.7.7.2.9 as follows:

2.9.7.7.2.9 Ensuring workers maintain daily communication notes for authorized services provided.

64. Section 2.9.7.7.4.4 shall be deleted and replaced as follows:

2.9.7.7.4.4 Fraud and abuse identification and reporting;

65. Section 2.9.7.7.4.7 shall be amended by deleting the word “and” from the end of the paragraph, Section 2.9.7.7.4.8 shall be deleted and replaced, and Section 2.9.7.7.4 shall be amended by adding a new Section 2.9.7.7.4.9 as follows:

2.9.7.7.4.8 As appropriate, administration of self-directed health care task(s). The member or his/her representative shall be responsible for training the worker(s) regarding individualized service needs and preferences and for specific training regarding health care tasks the member or his/her representative elects to self-direct (as applicable); and

2.9.7.7.4.9 Universal precautions and blood borne pathogens training.

66. Section 2.9.7.7.7 shall be deleted and replaced as follows:

2.9.7.7.7 The FEA shall be responsible for verifying and validating the worker’s completion of required CPR and First Aid training from an approved provider prior to initiation of services and payment for services. Ongoing, the FEA shall ensure that workers maintain CPR and first aid certification and receive required refresher training as a condition of continued employment. The FEA may assist workers in locating appropriate courses for initial certification and recertification as appropriate. Additional training components may be provided to a worker to address issues identified by the FEA, care coordinator, member and/or the representative or at the request of the worker.

67. Section 2.9.7.8.4 and 2.9.7.8.5 shall be deleted and replaced as follows:

2.9.7.8.4 The CONTRACTOR shall monitor implementation of the back-up plan by the member or his/her representative.

2.9.7.8.5 The CONTRACTOR shall monitor a member’s participation in consumer direction of eligible CHOICES HCBS to determine, at a minimum, the success and the viability of the service delivery model for the member. The CONTRACTOR shall note any patterns, such as frequent turnover of representatives or workers, habitual late and/or missed visits by workers, unauthorized schedule changes, failure to cooperate with the FEA and changing between consumer direction of eligible CHOICES HCBS and contract providers that may warrant intervention by the CONTRACTOR. The CONTRACTOR may submit a request to TENNCARE, pursuant to TennCare policy, to involuntarily withdraw the member from consumer direction of eligible CHOICES HCBS if the CONTRACTOR has concerns about its ability to protect the health, safety and welfare of the member (see Section 2.9.7.9.4). The FEA may submit a request to the CONTRACTOR to involuntarily withdraw the member from consumer direction of eligible CHOICES HCBS due to concerns regarding the member’s health, safety and welfare if the member continues in consumer direction. The



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CONTRACTOR must submit copies of all such requests to TENNCARE with documentation of its decision.

68. Section 2.9.8.4.5 shall be amended by deleting the reference “(see 2.9.6.9.2.1.16)” and replacing it with (See Section 2.9.6.9.2.1.17”).

69. Section 2.9.8.8.4 shall be deleted and replaced as follows:

2.9.8.8.4 If the short-term stay will exceed ninety (90) days, the CONTRACTOR shall facilitate transition from CHOICES Group 2 to CHOICES Group 1. A transition from Group 2 to Group 1 will not necessitate a member’s disenrollment from MFP, regardless of the length of stay in the facility, except in cases that care coordinator has assessed the reason for the re-institutionalization and determined that the member is not an appropriate candidate for continued enrollment in CHOICES Group 2 and MFP.

70. Section 2.9.8.5.2 shall be amended by adding the word “no” as follows:

2.9.8.5.2 Upon conclusion of the member’s 365-day participation period in MFP, the Plan of Care shall be updated to reflect that he is no longer participating in MFP.

71. The opening paragraph of Section 2.9.12.2 shall be deleted and replaced as follows:

(1) Services and Responsibilities

The CONTRACTOR shall coordinate with the DBM and/or the ID HCBS waiver contractor for dental services. Coordination of dental services, at a minimum, includes establishing processes for:

72. Section 2.9.12.3 shall be deleted and replaced as follows:

(2) Operating Principles

Coordinating the delivery of dental services to TennCare members is the primary responsibility of the DBM and/or the ID HCBS waiver contractor. However, the CONTRACTOR shall provide coordination assistance and shall be responsible for communicating the DBM/HCBS provider services, provider relations, and/or claim coordinator contact information to all of its contract providers. With respect to specific member issues, the CONTRACTOR shall work with the DBM/HCBS coordinator towards a resolution. Should systemic issues arise, the CONTRACTOR shall meet and resolve the issues with the DBM/HCBS waiver contractor. In the event that such issues cannot be resolved, the MCO and the DBM/HCBS waiver contractor shall meet with TENNCARE to reach final resolution of matters involved. Final resolution of system issues shall occur within ninety (90) calendar days from referral to TENNCARE.



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73. **Section 2.9.15.3 shall be amended by adding a new Section 2.9.15.3.1 which shall read as follows:**

2.9.15.3.1 If a member receiving home health or private duty nursing services will be subject to a reduction in covered services provided by the CONTRACTOR upon turning twenty-one (21) years of age and the member also receives HCBS Waiver services from DIDD, the CONTRACTOR, DIDD, and the Independent Support Coordinator (ISC) as applicable shall, pursuant to policies and processes established by TENNCARE, coordinate benefits to implement any changes in HCBS Waiver Services at the same time that MCO services are reduced to ensure as seamless a transition as possible.

74. **Section 2.11.8 shall be amended by adding a new Section 2.11.8.1.3 as follows and renumbering the existing Section accordingly, including any references thereto.**

2.11.8.1.3 To the extent the CONTRACTOR has delegated credentialing agreements in place with any approved delegated credentialing agency, the CONTRACTOR shall ensure all providers submitted to the CONTRACTOR from the delegated credentialing agent is loaded to its provider files and into its claims processing system within thirty (30) calendar days of receipt.

75. **Section 2.11.8.4.1.2.4 shall be amended by adding a new Section 2.11.8.4.1.2.4.1 as follows:**

2.11.8.4.1.2.4.1 Has a policy and process in place to address exception requests for workers who fail a criminal background check (see Section 2.9.7.6);

76. **Section 2.12.4 shall be deleted in its entirety and the existing Section 2.12.10 shall be deleted and replaced by a new Section 2.12.8 as follows, the remaining Sections shall be renumbered accordingly including any references thereto.**

2.12.8 No other terms or conditions agreed to by the CONTRACTOR and the provider shall negate or supersede the requirements listed in Section 2.12.9 below.

77. **Section 2.12.9.66.1 shall be deleted and replaced as follows:**

2.12.9.66.1 Language that no person on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin, or any other classifications protected under federal or state laws shall be excluded from participation in, except as specified in Section 2.3.5, or be denied benefits of, or be otherwise subjected to discrimination in the performance of provider's obligation under its agreement with the CONTRACTOR or in the employment practices of the provider.



78. The renumbered Section 2.12.10.10 shall be deleted and replaced as follows:

2.12.10.10 Require the nursing facility to comply with federal Preadmission Screening and Resident Review (PASRR) requirements applicable to all nursing facility residents, regardless of payor source, including ensuring that a level I screening has been completed prior to admission, a level II evaluation has been completed prior to admission when indicated by the level I screening, and a review is completed based upon a significant physical or mental change in the resident's condition that might impact the member's need for or benefit from specialized services. The facility shall collaborate with the CONTRACTOR and with other providers as needed to help ensure that current information regarding the member's mental health or intellectual disabilities needs (as available) is reflected in the PASRR screening in order to support an appropriate PASRR determination.

79. Section 2.13.1.2 shall be amended by deleting the existing Section 2.13.1.2.9 and replacing it with new Sections 2.13.1.2.9 and 2.13.1.2.10 as follows and the remaining Sections shall be renumbered accordingly, including any references thereto.

2.13.1.2.9 The CONTRACTOR agrees to implement retrospective episode based reimbursement and PCMH strategies consistent with Tennessee's multi-payer payment reform initiative in a manner and on a timeline approved by TENNCARE. This includes:

- 2.13.1.2.9.1 Using a the retrospective administrative process that is aligned with the model designed by TENNCARE;
- 2.13.1.2.9.2 Implementing key design choices as directed by TENNCARE, including the definition of each episode and definition of quality measures;
- 2.13.1.2.9.3 Delivering performance reports with same appearance and content as those designed by the state / payer coalition;
- 2.13.1.2.9.4 Implementation at a pace dictated by the State, likely 3-5 new episodes per quarter with appropriate lead time to allow payers and provider contracting;
- 2.13.1.2.9.5 Participate in a State-led process to design and launch new episodes, including the seeking of clinical input from payer medical teams and clinical leaders throughout Tennessee.

2.13.1.2.10 The CONTRACTOR shall implement State Budget Reductions and Payment Reform Initiatives, including retrospective episode based reimbursement, as described by TENNCARE. The CONTRACTOR's failure to implement State Budget Reductions and/or Payment Reform Initiatives as described by TENNCARE may, at the discretion of TENNCARE, result in the CONTRACTOR forfeiting savings that would have been realized based on the timely implementation, including the forfeiture of recoupment from providers.

80. Section 2.13.4.3 shall be deleted and replaced as follows:

2.13.4.3 If, prior to the end date specified by TENNCARE in its approval of Level II reimbursement for nursing facility services, the CONTRACTOR determines that the member no longer needs and/or the nursing facility is no longer providing the skilled and/or rehabilitative services for which Level II reimbursement of nursing facility services was approved by



TENNCARE, the CONTRACTOR shall notify TENNCARE and, as appropriate, shall submit a request to modify the member's level of reimbursement for nursing facility services. The CONTRACTOR shall submit documentation as specified by TENNCARE to support the request. The CONTRACTOR may reimburse the nursing facility at the Level I (rather than Level II) per diem rate only when such rate is billed by the nursing facility and there is an approved LOC eligibility segment for such level of reimbursement or upon approval from TENNCARE of a reduction in the member's level of care (i.e., reimbursement) as reflected on the outbound 834 enrollment file.

81. Section 2.14.1.15.1 shall be deleted and replaced as follows:

2.14.1.15.1 The CONTRACTOR shall ensure that level II reimbursement of nursing facility care is provided for CHOICES members who have been determined by TENNCARE to be eligible for Level II reimbursement of nursing facility care for the period specified by TENNCARE, except when level I reimbursement is billed by the nursing facility and there is an approved LOC eligibility segment for such level of reimbursement. The CONTRACTOR shall monitor the member's condition, and if the CONTRACTOR determines that, prior to the end date specified by TENNCARE, the member no longer requires and/or the facility is no longer providing the skilled and/or rehabilitative services for which Level II reimbursement of nursing facility care was approved by TENNCARE, the CONTRACTOR may submit to TENNCARE a request to modify the member's level of reimbursement for nursing facility services. The CONTRACTOR shall submit documentation as specified by TENNCARE to support the request. The CONTRACTOR may reimburse the nursing facility at the Level I (rather than Level II) per diem rate only when such rate is billed by the nursing facility and there is an approved LOC eligibility segment for such level of reimbursement or upon approval from TENNCARE of a reduction in the member's level of care (i.e., reimbursement) as reflected on the outbound 834 enrollment file.

82. Section 2.14.5.2 and Section 2.14.5.5 shall be deleted and replaced as follows:

2.14.5.2 The CONTRACTOR may decide whether it will issue service authorizations for nursing facility services, or whether it will instead process claims for such services in accordance with the level of care (i.e., reimbursement, including the duration of such level of reimbursement) approved by TENNCARE (see Section 2.14.1.15), except that the CONTRACTOR may reimburse a facility at the Level I per diem rate when such lesser rate is billed by the facility and there is an approved LOC eligibility segment for such level of reimbursement.

2.14.5.5 The CONTRACTOR may determine the duration of time for which CHOICES HCBS will be authorized. However, the CONTRACTOR shall be responsible for monitoring its authorizations and for ensuring that there are no gaps in authorizations for CHOICES HCBS in accordance with the plan of care. The CONTRACTOR shall further be responsible for ensuring that service authorizations are consistent with the plan of care, including the schedule at which services are needed and any updates to the plan of care and/or schedule, and except in the following circumstance, for notifying providers in advance when a service authorization (including a schedule) will be changed. Retroactive entry or adjustments in service authorizations for CHOICES HCBS should be made only when required to



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accommodate payment of services that had been authorized but an adjustment in the schedule of services was required based on the member's needs.

83. Sections 2.15.3.1 through 2.15.3.2.6 shall be deleted and replaced as follows:

- 2.15.3.1 The CONTRACTOR shall perform at least two (2) clinical and three (3) non-clinical PIPs. Clinical PIPs include projects focusing on prevention and care of acute and chronic conditions, high-volume services, high-risk services, and continuity and coordination of care; non-clinical PIPs include projects focusing on availability, accessibility, and cultural competency of services, interpersonal aspects of care, and appeals, grievances, and other complaints.
- 2.15.3.1.1 The two (2) clinical PIPs shall include one (1) in the area of behavioral health that is relevant to one of the Population Health programs for bipolar disorder, major depression, or schizophrenia and one (1) in the area of either child health or perinatal (prenatal/postpartum) health.
- 2.15.3.1.2 One (1) of the three (3) non-clinical PIPs shall be in the area of long-term care. The CHOICES special study may not be used as a PIP. The CONTRACTOR shall use existing processes, methodologies, and protocols, including the CMS protocols.
- 2.15.3.2 The CONTRACTOR shall ensure that CMS protocols for PIPs are followed and that all steps outlined in the CMS protocols for performance improvement projects are documented.

84. Section 2.15.6.2 shall be deleted and replaced as follows:

- 2.15.6.2 Annually, the CONTRACTOR shall conduct a CAHPS survey. The CONTRACTOR shall enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys. The CONTRACTOR's vendor shall perform the CAHPS adult survey, CAHPS child survey and the CAHPS children with chronic conditions survey using the most current CAHPS version specified by NCQA. Survey results shall be reported to TENNCARE separately for each required CAHPS survey listed above. Survey results shall be submitted to TENNCARE, NCQA and TENNCARE's EQRO annually by June 15 of each calendar year.

85. Section 2.15.7.1.4.3, 2.15.7.1.4.6, and 2.15.7.1.4.7 shall be deleted and replaced as follows:

- 2.15.7.1.4.3 Requiring that its staff and contract CHOICES HCBS providers immediately (which shall not exceed twenty-four hours) take steps to prevent further harm to any and all members and respond to any emergency needs of members. If the allegation is in reference to a CHOICES HCBS worker, the worker shall be immediately released from providing services to any TennCare member until the investigation is complete.
- 2.15.7.1.4.6 Defining the role and responsibilities of the fiscal employer agent (see definition in Section 1) in reporting, any critical incidents, which shall include reporting incidents to the CONTRACTOR using the process developed in accordance with Section 2.15.7.1.4.1, and reporting to the CONTRACTOR within 24 hours in accordance with the abuse and neglect plan protocols anytime there is a suspicion of abuse or neglect (see Section 2.9.7.8.6); training employees, contractors of the FEA (including supports brokers), and consumer-directed workers regarding reporting, and cooperating with the



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investigation of any critical incidents; and training consumers and caregivers regarding critical incident reporting and management. Such role and responsibilities shall be defined in a manner that is consistent with requirements in this Section 2.15.7.1.4 as well as TENNCARE's contract with the fiscal employer agent and the model contract between the CONTRACTOR and the FEA.

2.15.7.1.4.7 Reviewing any FEA reports regarding critical incidents and investigate, as appropriate to determine any necessary corrective actions needed by the member and/or his/her representative to help ensure the member's health and safety.

86. Section 2.15.7 shall be amended by adding a new Section 2.15.7.3 and renumbering the remaining Section accordingly, including any references thereto.

2.15.7.3 Home Health Agency Critical Incident Reporting

2.15.7.3.1 The CONTRACTOR shall identify and track all significant Home Health Agency (HHA) critical incidents involving non-CHOICES enrollees. A HHA critical incident shall include those significant incidents that are reported to the CONTRACTOR from the HHA including unexpected death, major/severe injury, safety issues, or suspected physical, mental or sexual abuse or neglect. Each incident must be reported using the TENNCARE prescribed HHA Critical Incident report template within twenty-four (24) hours of the CONTRACTOR receiving information relative to such an incident. An updated report, including results of investigation and next steps must be submitted to TENNCARE within thirty (30) calendar days of notification of the incident.

87. Section 2.17.4.7.27 shall be amended by deleting the phrase “, and DHS” and deleting and replacing the phrase “failure to notify DHS” with “failure to notify TENNCARE.”

88. Section 2.17.5.3.5 shall be deleted and replaced as follows:

2.17.5.3.5 A notice of the right to file a discrimination complaint, as provided for by applicable federal and state civil rights laws, including, but not limited to Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, Title IX of the Education amendments of 1972, Section 504 of the Rehabilitation Act of 1973, and Titles II and III of the Americans with Disabilities Act of 1990 that includes a phone number for assistance and a website link to the complaint form. The notice shall be considered a Vital Document and shall be available at a minimum in the English and Spanish languages;

89. Section 2.18.10.2 shall be deleted and replaced as follows:

2.18.10.2 The CONTRACTOR shall provide an education plan for all members with behavioral health issues; education shall occur on a regular basis. At a minimum, educational materials shall include information on medications and their side effects; behavioral health disorders and treatment options; self-help groups, peer recovery services, family support services, and other community support services available for members and families.



90. Section 2.19.3.18 shall be deleted and replaced as follows:

2.19.3.18 Member TennCare eligibility and eligibility-related grievances and appeals (including but not limited to long-term care eligibility and enrollment), including termination of eligibility, effective dates of coverage, and the determination of premium, copayment, and patient liability responsibilities shall be directed to TENNCARE.

91. Section 2.20.1.8 shall be amended by deleting the word “repayment” and replacing it with the phrase “recoupment or withhold” as follows:

2.20.1.8 This prohibition described above in Section 2.20.1.7 shall be limited to a specific provider(s), for specific dates, and for specific issues, services or claims. The CONTRACTOR shall check with the Bureau of TennCare, Program Integrity Unit before initiating any recoupment or withhold of any program integrity related funds (See Section 2.20.1.7) to ensure that the recoupment or withhold is permissible. In the event that the CONTRACTOR obtains funds in cases where recoupment or withhold is prohibited under this section, the CONTRACTOR will return the funds to the provider.

92. Section 2.20.2.11 shall be amended by adding a new sentence as follows:

2.20.2.11 The CONTRACTOR, subcontractor and providers, whether contract or non-contract, shall, upon request and as required by this Contract or state and/or federal law, make available to the TBI MFCU/OIG any and all administrative, financial and medical records relating to the delivery of items or services for which TennCare monies are expended. Such records will be made available at no cost to the requesting agency. In addition, the TBI MFCU/OIG shall, as required by this Contract or state and/or federal law, be allowed access to the place of business and to all TennCare records of any contractor, subcontractor or provider, whether contract or non-contract, during normal business hours, except under special circumstances when after hour admission shall be allowed. Special circumstances shall be determined by the TBI MFCU/OIG.

93. Section 2.22.5 shall be amended by adding a new Section 2.22.5.4 as follows:

2.22.5.4 The CONTRACTOR shall monitor, on an at least a monthly basis, the number of each long-term care provider’s denied claims for long-term care services (NF and CHOICES HCBS), and shall initiate training and technical assistance as needed to any long-term care provider whose monthly volume of denied claims for long-term care services exceeds twenty percent (20%). The CONTRACTOR shall submit to TENNCARE on a quarterly basis, a report of all long-term care contractors for whom the number of denied claims for long-term care services exceeded twenty percent (20%) of the total number of claims for long-term care services submitted during any month, the total number and percent of denied claims for long-term care services for that month, the total dollar value of denied claims for long-term care services, the type of intervention (e.g., training or technical assistance) determined to be needed and provided by the CONTRACTOR, and the current status of such denied claims (e.g., resubmitted, pending action by the provider, determined to be duplicate claims, etc.).



94. Section 2.24.4.3 shall be deleted and replaced as follows:

2.24.4.3 The CONTRACTOR's abuse and neglect plan shall also define the role and responsibilities of the FEA and supports broker (see definition in Section 1) in assessing and reducing a member's risk of abuse and neglect, identifying and reporting abuse and neglect, protecting a member if abuse and/or neglect is suspected; training employees, contractors of the FEA (including supports brokers), and consumer-directed workers regarding the protocols identified in Sections 2.24.4.2.1 through 2.24.4.2.6 above; and training members and caregivers regarding identification and reporting of suspected abuse and/or neglect. Such role and responsibilities shall be defined in a manner that is consistent with requirements in this Section 2.24.4 as well as TENNCARE's contract with the fiscal employer agent and the model contract between the CONTRACTOR and the FEA.

95. Sections 2.27.5.14, 2.27.5.20 and 2.27.5.24 shall be deleted and replaced as follows:

2.27.5.14 Create and implement policies and procedures to address present and future HIPAA/HITECH regulatory requirements as needed, including, but not limited to: use and disclosure of data; de-identification of data; minimum necessary access; accounting of disclosures; enrollee's right to amend, access, request restrictions; notice of privacy practices and right to file a complaint, and breach notification;

2.27.5.20 Continue to protect and secure PHI AND personally identifiable information relating to enrollees who are deceased for fifty (50) years following the date of an enrollee's death, effective September 23, 2013;

2.27.5.24 Obtain a third (3rd) party certification of their HIPAA standard transaction compliance ninety (90) calendar days before the start date of operations, if applicable, and upon request by TENNCARE.

96. Section 2.27.9.4.7 shall be deleted and replaced as follows:

2.27.9.4.7 If a court issues a subpoena for a case record or for any CONTRACTOR representative to testify concerning an applicant or beneficiary, the CONTRACTOR must notify the State at least ten (10) days prior to the required production date so the State may work with the CONTRACTOR regarding CONTRACTOR's informing the court of the applicable statutory provisions, policies, and regulations restricting disclosure of information, effective until Jan. 1, 2014; and

97. Sections 2.27.10.11.2, 2.27.10.11.3, and 2.27.10.11.4 shall be deleted and replaced as follows:

2.27.10.11.2 "Protected Health Information/Personally Identifiable Information" (PHI/PII) (45 C.F.R. § 160.103; OMB Circular M-06-19) – "Protected health information" or "PHI" means individually identifiable health information that is: (i) Transmitted by electronic media; (ii) Maintained in electronic media; or (iii) Transmitted or maintained in any other form or medium.

2.27.10.11.3 "Personally Identifiable information" or "PII" refers to any information about an individual maintained by an agency, including, but not limited to, education, financial



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transactions, medical history, and criminal or employment history and information which can be used to distinguish or trace an individual's identity, such as their name, social security number, biometric records, etc., alone, or when combined with other personal or identifying information which is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name, etc.

- 2.27.10.11.4 "Individually Identifiable Health Information" – information that is a subset of health information, including demographic information collected from an individual, and: (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) identifies the individual; or (ii) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

98. Sections 2.27 shall be amended by adding new Sections 2.27.11 through 2.27.13 as follows:

- 2.27.11 Sensitive Data Related to Alcohol and Drug Abuse Enrollee Records for Substance Abuse Treatment.
- 2.27.11.1 This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2.
- 2.27.11.2 A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. 42 C.F.R. § 2.32 (SAMHSA)
- 2.27.12 Federal Tax Information (FTI).
- 2.27.12.1 Any FTI made available shall be used only for the purpose of carrying out the provisions of this Contract.
- 2.27.12.2 Information contained in such material shall be treated as confidential and shall not be divulged or made known in any manner to any person except as may be necessary in the performance of this Contract. Inspection by or disclosure to anyone other than an officer of employer of the Grantee is strictly prohibited.
- 2.27.13 Failure to comply with federal regulations regarding HIPAA/HITECH, SSA, Medicaid, CHIP, SAMHSA, and FTI data may result in criminal and civil fines and penalties.

99. Sections 2.28.3, 2.28.6.2, and 2.28.7 shall be deleted and replaced as follows:

- 2.28.3 The CONTRACTOR's non-discrimination compliance plan shall include written policies and procedures that demonstrate non-discrimination in the provision of services to members. The policy shall also demonstrate non-discrimination in the provision of language assistance services for members with Limited English Proficiency and those requiring communication assistance in alternative formats (see Section 2.18.2). These policies and procedures shall be prior approved in writing by TENNCARE.



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2.28.6.2 Discrimination Complaints against the CONTRACTOR's Providers, Provider's Employees and/or Provider's Subcontractors. Should complaints concerning alleged acts of discrimination committed by the CONTRACTOR's providers, provider's employees and/or subcontractors related to the provision of and/or access to TennCare covered services be reported to the CONTRACTOR, the CONTRACTOR's nondiscrimination compliance officer shall inform TENNCARE of such complaints within two (2) business days from the date CONTRACTOR learns of such complaints. If TENNCARE requests that the CONTRACTOR'S nondiscrimination compliance officer assist TENNCARE with conducting the initial investigation, the CONTRACTOR'S nondiscrimination compliance officer within five (5) business days from the date of the request shall start the initial investigation. Once an initial investigation has been completed, the CONTRACTOR's nondiscrimination compliance officer shall report his/her determinations to TENNCARE. At a minimum, the CONTRACTOR's nondiscrimination compliance officer's report shall include the identity of the party filing the complaint; the complainant's relationship to the CONTRACTOR; the circumstances of the complaint; date complaint filed; and the CONTRACTOR's suggested resolution. TENNCARE shall review the CONTRACTOR's initial investigations and determine the appropriate resolutions for the complaints as set forth in Section 2.28.6.3 below. TENNCARE reserves the right to investigate and resolve all complaints concerning alleged acts of discrimination committed by the CONTRACTOR's providers, and subcontractors.

2.28.7 The CONTRACTOR shall use and have available to TennCare enrollees, TennCare's Discrimination complaint form located on TennCare's website under the nondiscrimination link at <http://www.tn.gov/tennCare/members.shtml>. The discrimination complaint form shall be provided to TennCare enrollees upon request and in the member handbook. This complaint form shall be considered a Vital Document and shall be available at a minimum in the English and Spanish languages. When requests for assistance to file a discrimination complaint are made by enrollees, the CONTRACTOR shall assist the enrollees with submitting complaints to TENNCARE. In addition, the CONTRACTOR shall inform its employees, providers, and subcontractors how to assist TENNCARE enrollees with obtaining discrimination complaint forms and assistance from the CONTRACTOR with submitting the forms to TENNCARE and the CONTRACTOR.

100. Section 2.29.1.3 shall be amended by adding a new Section 2.29.1.3.19 as follows and the remaining Section shall be renumbered accordingly, including any references thereto.

2.29.1.3.19 A staff person to serve as the Litigation Hold Contact. This individual shall be responsible for responding to all litigation hold requests from TENNCARE;

101. Section 2.30.1 shall be amended by adding a new Section 2.30.1.8 which shall read as follows:

2.30.1.8 In accordance with the requirements set forth in 42 U.S.C. § 300kk, the CONTRACTOR must develop and maintain the ability to collect and report data on race, ethnicity, sex, primary language, and disability status for applicants and members and from applicants' and members' parents or legal guardians if applicants or members are minors or legally incapacitated individuals. In collecting this data the CONTRACTOR shall use the Office of Management and Budget (OMB) standards, at a minimum, for race and ethnicity measures. Race and Ethnic Standards established for *Federal Statistics and Administrative Reporting* include the following categories as defined by the OMB:



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2.30.1.8.1 Race – American Indian or Alaska Native, Asian, black or African American, native Hawaiian or other Pacific Islander, white;

2.30.1.8.2 Ethnicity – Hispanic or Latino, Not Hispanic or Latino.

102. Section 2.30.5 through 2.30.5.3 shall be deleted and replaced as follows:

2.30.5 Population Health Reports

2.30.5.1 The CONTRACTOR shall submit a quarterly *Population Health Update Report* addressing all seven (7) Population Health Programs (see Section 2.8.4 of this Contract). The report shall include process and operational data and any pertinent narrative to include any staffing changes, training or new initiatives occurring in the reporting period.

2.30.5.2 The CONTRACTOR shall submit a quarterly *Population Health Stratification Data Report*, through the current secure system, which shall include a list in Comma Separated Value (CSV) format consisting of the name, ID, DOB, stratification or all risk levels and the corresponding dates of eligibility for the level and program assignments for all of the CONTRACTOR's members (see Section 2.8.11.5).

2.30.5.3 The CONTRACTOR shall submit annually, on December 1 after the close of the state fiscal year, a *Population Health Annual Report* in the format described in the annual report template provided by TENNCARE. The report shall include active participation rates, as designated by NCQA, for programs with active interventions. Short term and intermediate outcome data reporting is required. Member satisfaction shall be reported based upon NCQA requirements along with functional status for members in the Chronic Care Management and Complex Case Management programs.

2.30.5.4 The CONTRACTOR shall submit annually on March 30, a *Population Health Program Description* following the guidance provided by TENNCARE addressing Section 2.8 of this Contract. The program description shall include a written description of how the plan assures that members less than 21 years of age will have their health risks identified and their health needs met at the appropriate risk Level. The program description shall also include a CHOICES narrative as outlined in Section 2.8.11 of this Contract and address the Clinical Practice Guidelines reference in Section 2.8.6 of this Contract.

103. Sections 2.30.6.1 through 2.30.6.1.3 shall be deleted in their entirety and the remaining Sections shall be renumbered accordingly, including any references thereto.



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104. Section 2.30.6 shall be amended by adding a new Section 2.30.6.4 as follows and renumbering the remaining Sections accordingly.

2.30.6.4 Upon enrollment of CHOICES Group 2 or 3 members (if and when directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3), the CONTRACTOR shall submit a monthly *Nursing Facility Short-Term Stay Report* in a format specified by TENNCARE that includes but is not limited to, for each Group 2 and Group 3 member utilizing the short-term NF stay benefit, the name of each Group 2 and Group 3 member receiving short-term NF services, the NF in which s/he currently resides, the date of admission for short-term stay, the number of days of short-term NF stay utilized for this admission, and the anticipated date of discharge back to the community. For any member exceeding the ninety (90)-day limit on short-term NF stay, the CONTRACTOR shall include explanation regarding why the benefit limit has been exceeded, and specific actions the CONTRACTOR is taking to facilitate discharge to the community or transition to Group 1, as applicable, including the anticipated timeline.

105. Section 2.30.12 shall be amended by adding back Section 2.30.12.9 as follows which was previously deleted in error.

2.30.12.9 The CONTRACTOR shall submit a quarterly Behavioral Health Adverse Occurrences Report in accordance with Section 2.15.7.2 that provides information, by month regarding specified measures, which shall include but not be limited to the following:

2.30.12.9.1 The number of adverse occurrences, overall and by:

2.30.12.9.1.1 Date of occurrence

2.30.12.9.1.2 Type of adverse occurrence;

2.30.12.9.1.3 Location;

2.30.12.9.1.4 Provider name; and

2.30.12.9.1.5 Action Taken by Facility/Provider.

106. Section 2.30.17 shall be amended by adding a new Section 2.30.17.6 as follows:

2.30.17.6 The CONTRACTOR shall submit to TENNCARE on a quarterly basis, a Denied Claims Report on all long-term care contractors (NF and HCBS) for whom the number of denied claims for long-term care services exceeded twenty percent (20%) of the total number of claims for long-term care services submitted during any month. The report shall include the name and provider number of the long-term care contractor, the total number and percent of denied claims for long-term care services for that month, the total dollar value of denied claims for long-term care services, the type of intervention (e.g., training or technical assistance) determined to be needed and provided by the CONTRACTOR, and the current status of such denied claims (e.g., resubmitted, pending action by the provider, determined to be duplicate claims, etc.).



107. Section 3.4.8 shall be deleted and replaced as follows:

3.4.8 In the event the amount of the five and one half percent (5.5%) premium tax is increased or decreased during the term of this Contract, the payments shall be increased or decreased by an amount equal to the increase/decrease in premium payable by the CONTRACTOR.

108. Section 4.9.1 shall be deleted and replaced as follows:

4.9.1 In no event shall the maximum liability of the State under this Agreement during the original term of the Contract exceed three billion, three hundred eighty four million, six hundred sixty three thousand, six hundred five dollars and ninety cents (\$3,384,663,605.90).

109. Section 5.4.7.2.12 shall be deleted and replaced as follows:

5.4.7.2.12 File all reports concerning the CONTRACTOR's operations during the term of the Contract in the manner described in this Contract. Required reporting shall include, but not be limited to any necessary data and/or reporting required to comply with the Medicaid Payment for Primary Care as required in Section 2.13.9 of this Contract;

110. Section 5.20.2.2.7 shall be amended by adding new PROGRAM ISSUES, LEVELs A.33 and A.34 as follows:

<p>A.33</p>	<p>Failure to ensure that a member utilizing the short-term stay benefit is transitioned from Group 2 or Group 3, as applicable, to Group 1 at any time a) it is determined that the stay will not be short-term or the member will not transition back to the community; and b) prior to exhausting the ninety (90)-day short-term NF benefit covered for CHOICES Group 2 and Group 3 members (see Section 2.6.1.5.3.1)</p>	<p>\$500 per day, per occurrence for each calendar day that a member exceeds the ninety (90) day benefit limit in accordance with this agreement. These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing recommendations as specified in Section 2.9.6.11.9 of this Contract</p>
<p>A.34</p>	<p>Failure to complete and submit to TENNCARE at least eight (8) business days prior to expiration of a member's current LOC eligibility segment, a new LOC assessment, including all required supporting documentation needed to appropriately determine the member's LOC eligibility going forward (see Section 2.9.6.9.3.1.2)</p>	<p>\$500 per day, per occurrence for each calendar day beyond eight (8) business days prior to expiration of the member's current LOC eligibility segment. These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing recommendations as specified in Section 2.9.6.11.9 of this Contract</p>



111. Section 5.32.1 shall be deleted and replaced as follows:

5.32.1 No person on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin, or any other classifications protected under federal or state laws shall be excluded from participation in, except as specified in Section 2.3.6 of this Contract, or be denied benefits of, or be otherwise subjected to discrimination in the performance of this Contract or in the employment practices of the CONTRACTOR.

112. Mental Health Case Management Services in Attachment I shall be amended by deleting and replacing the paragraphs labeled “Level 2a and Level 2b” as follows:

Level 2a and Level 2b

Level 2 mental health case management is a less intensive level of service than Level 1 and is focused on resilience and recovery. The CONTRACTOR shall ensure that level 2 mental health case management is provided to individuals whose symptoms are at least partially stabilized or reduced in order to allow treatment and rehabilitation efforts.

Where available, peer recovery services and family support services may be used as an adjunct to the case manager in monitoring the member prior to discharge from Level 2 case management. However, at no time should peer recovery services and family support services in the form of Certified Peer Recovery Specialist and/or Certified Family Support Specialists, or any other form, become a substitute for case managers in the delivery of case management services.

113. Psychiatric Rehabilitation Services in Attachment I shall be amended by deleting and replacing the paragraphs labeled “Peer Support” and adding new paragraphs labeled Family Support Services as follows:

Peer Recovery Services

Peer recovery services allow individuals to direct their own recovery and advocacy process and are provided by persons who are or have been consumers of the behavioral health system and are Certified Peer Recovery Specialists. A Certified Peer Recovery Specialist is a person who has identified himself or herself as having received or is receiving mental health, substance abuse or co-occurring disorder services in his or her personal recovery process, has undergone training recognized by the Tennessee Department of Mental Health and Substance Abuse Services on how to assist peers with the recovery process and received certification.

These services include providing assistance with more effectively utilizing the service delivery system (e.g. assistance in developing plans of care, accessing services and supports, partnering with professionals) or understanding and coping with the stressors of the person’s illness through support groups, role modeling, and mentoring. Activities which promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills are rendered so individuals can educate and support each other in the acquisition of skills needed to manage their illnesses and access resources within their communities. Services are often provided during the evening and weekend hours.



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Family Support Services

Family support services are used to assist other caregivers of children or youth diagnosed with emotional, behavioral, or co-occurring disorders, and are provided by persons who are a Certified Family Support Specialist. A Certified Family Support Specialist is a person who has previously self-identified as the caregiver of a child or youth with an emotional, behavioral or co-occurring disorder and who has successfully navigated the child-serving systems to access treatment and resources necessary to build resiliency and foster success in the home, school, and community. This individual has successfully completed training recognized by TDMHSAS on how to assist other caregivers in fostering resiliency in their child based on the principles of resiliency and recovery.

These services include assisting caregivers in managing their child's illness and fostering resiliency and hope in the recovery process. These direct caregiver-to-caregiver support services include, but are not limited to, developing formal and informal supports, assisting in the development of strengths-based family and individual goals, serving as an advocate, mentor, or facilitator for resolution of issues that a caregiver is unable to resolve on his or her own, or providing education on system navigation and skills necessary to maintain a child with emotional, behavioral or co-occurring disorders in their home environment.

- 114. The Definition under Crisis Services in Attachment I shall be deleted and replaced as follows:**

Definition

Behavioral health crisis services shall be rendered to individuals with a mental health or substance use/abuse issue when there is a perception of a crisis by an individual, family member, law enforcement, hospital staff or others who have closely observed the individual experiencing the crisis. Crisis services are available twenty-four (24) hours a day, seven (7) days a week. Crisis services include twenty-four (24) hour toll free telephone lines answered in real time by trained crisis specialists and face-to-face crisis services including, but not limited to: prevention, triage, intervention, evaluation/referral for additional services/treatment, and follow-up services. Certified Peer Recovery Specialists and/or Certified Family Support Specialists shall be utilized in conjunction with crisis specialists to assist adults and children in alleviating and stabilizing crises and promote the recovery process as appropriate. Behavioral health crisis service providers are not responsible for pre-authorizing emergency involuntary hospitalizations.

The Mental Health Crisis Response Services - Community Face-to-Face Response Protocols provide guidance for calls that are the responsibility of a crisis response service to determine if a Face-to-Face evaluation is warranted and those that are not the responsibility of the crisis response service. These Protocols were developed to ensure that consumers who are experiencing a behavioral health crisis and have no other resources receive prompt attention. All responses are first determined by clinical judgment.

Guidance for All Calls:

- For calls originating from an Emergency Dept., telehealth is the preferred service delivery method for the crisis response service
- After determining that there is no immediate harm, ask the person if he or she can come to the closest walk-in center
- If a Mandatory Pre-screening Agent (MPA) not employed by a crisis response service is available, there may be no need for a crisis evaluation by mobile crisis
- For all other calls, unless specified in the Protocols, if a person with mental illness is experiencing the likelihood of immediate harm then a response is indicated.



115. Attachment III shall be deleted and replaced as follows:

**ATTACHMENT III
GENERAL ACCESS STANDARDS**

In general, contractors shall provide available, accessible, and adequate numbers of institutional facilities, service locations, service sites, professional, allied, and paramedical personnel for the provision of covered services, including all emergency services, on a 24-hour-a-day, 7-day-a-week basis. At a minimum, this shall include:

- Primary Care Physician or Extender:
 - (a) Distance Rural: 30 miles
 - (b) Distance Urban: 20 miles
 - (c) Patient Load: 2,500 or less for physician; one-half this for a physician extender.
 - (d) Appointment/Waiting Times: Usual and customary practice (see definition below), not to exceed 3 weeks from date of a patient's request for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.
 - (e) Documentation/Tracking requirements:
 - + Documentation - Plans must have a system in place to document appointment scheduling times.
 - + Tracking - Plans must have a system in place to document the exchange of member information if a provider, other than the primary care provider (i.e., school-based clinic or health department clinic), provides health care.
- Specialty Care and Emergency Care: Referral appointments to specialists (e.g., specialty physician services, hospice care, home health care, substance abuse treatment, rehabilitation services, etc.) shall not exceed 30 days for routine care or 48 hours for urgent care. All emergency care is immediate, at the nearest facility available, regardless of contract. Waiting times shall not exceed 45 minutes.
- Hospitals
 - (a) Transport distance will be the usual and customary, not to exceed 30 miles, except in rural areas where access distance may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented to the State on the basis of community standards.
- Long-Term Care Services:

Transport distance to licensed Adult Day Care providers will be the usual and customary not to exceed 20 miles for TennCare enrollees in urban areas, not to exceed 30 miles for TennCare enrollees in suburban areas and not to exceed 60 miles for TennCare enrollees in rural areas except where community standards and documentation shall apply.



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- General Optometry Services:
 - (a) Transport distance will be the usual and customary, not to exceed 30 miles, except in rural areas where community standards and documentation shall apply.
 - (b) Appointment/Waiting Times: Usual and customary not to exceed 3 weeks for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.
- All other services not specified here shall meet the usual and customary standards for the community as determined by TENNCARE.

TENNCARE will evaluate the need for further action when the above standards are not met. At its sole discretion TENNCARE may elect one of three options: (1) TENNCARE may request a Corrective Action Plan (CAP), (2) a Request for Information (RFI), (3) or an On Request Report (ORR) depending on the severity of the deficiency.

The requested CAP, RFI or ORR response shall detail the CONTRACTOR's network adequacy considering any alternate measures, documentation of unique market conditions and/or its plan for correction. If TENNCARE determines the CONTRACTOR's response demonstrates existence of alternate measures or unique market conditions, TENNCARE may elect to request periodic updates from the CONTRACTOR regarding efforts to address such conditions.

116. Attachment V shall be deleted and replaced as follows:

**ATTACHMENT V
ACCESS & AVAILABILITY FOR BEHAVIORAL HEALTH SERVICES**

The CONTRACTOR shall adhere to the following behavioral health network requirements to ensure access and availability to behavioral health services for all members (adults and children). For the purpose of assessing behavioral health provider network adequacy, TENNCARE will evaluate the CONTRACTOR's provider network relative to the requirements described below. Providers serving adults will be evaluated separately from those serving children.

Access to Behavioral Health Services

The CONTRACTOR shall ensure access to behavioral health providers for the provision of covered services. At a minimum, this means that:

The CONTRACTOR shall have provider agreements with providers of the services listed in the table below and meet the geographic and time for admission/appointment requirements.



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Service Type	Geographic Access Requirement	Maximum Time for Admission/ Appointment
Psychiatric Inpatient Hospital Services	Travel distance does not exceed 90 miles for at least 90% of members	4 hours (emergency involuntary)/24 hours (involuntary)/24 hours (voluntary)
24 Hour Psychiatric Residential Treatment	<p>The CONTRACTOR shall contract with at least one (1) provider of service in the Grand Region for ADULT members</p> <p>-----</p> <p>Travel distance does not exceed 60 miles for at least 75% of CHILD members and does not exceed 90 miles for at least 90% of CHILD members</p>	Within 30 calendar days
Outpatient Non-MD Services	Travel distance does not exceed 30 miles for ALL members	Within 10 business days; if urgent, within 48 hours
Intensive Outpatient (may include Day Treatment (adult), Intensive Day Treatment (Children & Adolescent) or Partial Hospitalization)	Travel distance does not exceed 90 miles for at least 90% of members	Within 10 business days; if urgent, within 48 hours
Inpatient Facility Services (Substance Abuse)	Travel distance does not exceed 90 miles for at least 90% of members	Within 2 calendar days; for detoxification - within 4 hours in an emergency and 24 hours for non-emergency
24 Hour Residential Treatment Services (Substance Abuse)	<p>The CONTRACTOR shall contract with at least one (1) provider of service in the Grand Region for ADULT members</p> <p>-----</p> <p>The CONTRACTOR shall contract with at least one (1) provider of service in the Grand Region for CHILD members</p>	Within 10 business days
Outpatient Treatment Services (Substance Abuse)	Travel distance does not exceed 30 miles for ALL members	Within 10 business days; for detoxification – within 24 hours
Mental Health Case Management	Not subject to geographic access standards	Within 7 calendar days
Psychosocial Rehabilitation (may include Supported Employment, Illness Management)	Not subject to geographic access standards	Within 10 business days



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& Recovery, Peer Recovery services or Family Support service		
Supported Housing	Not subject to geographic access standards	Within 30 calendar days
Crisis Services (Mobile)	Not subject to geographic access standards	Face-to-face contact within 1 hour for emergency situations and 4 hours for urgent situations
Crisis Stabilization	Not subject to geographic access standards	Within 4 hours of referral

TENNCARE will evaluate the need for further action when the above standards are not met. At its sole discretion TENNCARE may elect one of three options: (1) TENNCARE may request a Corrective Action Plan (CAP), (2) a Request for Information (RFI), (3) or an On Request Report (ORR) depending on the severity of the deficiency.

The requested CAP, RFI or ORR response shall detail the CONTRACTOR's network adequacy considering any alternate measures, documentation of unique market conditions and/or its plan for correction. If TENNCARE determines the CONTRACTOR's response demonstrates the existence of alternate measures or unique market conditions, TENNCARE may elect to request periodic updates from the CONTRACTOR regarding efforts to address such conditions.

At a minimum, providers for the following service types shall be reported on the Provider Enrollment File:

Service Type	Service Code(s) for use in position 330-331 of the Provider Enrollment File
Psychiatric Inpatient Hospital Services	Adult - 11, 79, 85 Child - A1 or H9
24 Hour Psychiatric Residential Treatment	Adult - 13, 81, 82 Child - A9, H1, or H2
Outpatient MD Services (Psychiatry)	Adult - 19 Child - B5
Outpatient Non-MD Services	Adult - 20 Child - B6
Intensive Outpatient/ Partial Hospitalization	Adult - 21, 23, 62 Child - B7, C2, C3
Inpatient Facility Services (Substance Abuse)	Adult - 15, 17 Child - A3, A5
24 Hour Residential Treatment Services (Substance Abuse)	Adult - 56 Child - F6
Outpatient Treatment Services (Substance Abuse)	Adult - 27 or 28 Child - D3 or D4
Mental Health Case Management	Adult - 31, 66, or 83 Child - C7, D7, G2, G6, or K1



Amendment 33 (cont.)

Psychiatric Rehabilitation Services:	
Psychosocial Rehabilitation	42
Supported Employment	44
Peer Recovery Services	88
Family Support Services	49
Illness Management & Recovery	91
Supported Housing	32 and 33
Crisis Services (Mobile)	Adult - 37, 38, 39 Child - D8, D9, E1
Crisis Respite	Adult - 40 Child - E2
Crisis Stabilization	Adult 41

117. Exhibit B of Attachment IX shall be amended by deleting the word “Peer Support” and replacing it with “Peer Recovery Services and Family Support Services”.
118. Attachment XII shall be deleted and replaced as follows:

**ATTACHMENT XII
COMMUNITY HEALTH RECORD**

- I. Program Requirements
1. The CONTRACTOR shall receive data files from TENNCARE for all TennCare enrollees that include the following:
- a. Membership and eligibility file. Each daily transmission will meet the 270/271 standard transaction format.
 - b. Medical claim encounter data from all Managed Care Organizations (MCO). Each weekly transmission will include all claims processed by each MCO for the prior period.
 - c. Pharmacy claim encounter data shall be provided on a weekly basis. Each transmission will include all pharmacy claims processed for the prior period.
 - d. Provider file shall be provided on a monthly basis and shall include the National Provider Identifier for each provider; however, TENNCARE shall not be responsible for linking each provider to a common provider number for said file.
2. The CONTRACTOR shall provide data integration services for all TennCare enrollees which include maintaining an Enterprise Master Person Index (EMPI). The EMPI provides a central repository for person-centric data from a variety of contributing systems, and facilitates the integrity of a single person record. The mission of the EMPI is to provide functionality to find the right person with the right information at the right time as well as provide a solution to identify and eliminate as many duplicate records as possible.



Amendment 33 (cont.)

3. The CONTRACTOR shall provide a clinical health record for children entering State custody to the assigned Best Practice Network provider that includes the following components:
 - a. Patient Demographics;
 - b. Diagnosis and procedures from claims detail;
 - c. Medication information from claims detail;
 - d. Immunization information from claims detail; and
 - e. Allergy information, if available.
4. The CONTRACTOR shall make a system available to extract and compile a clinical health record that will be made available on demand to the Department of Children Services (DCS) through a web based application once a child has entered into State custody.
5. Upon notification and identification of the primary care provider assigned to a child who recently entered State custody, the CONTRACTOR shall make available to the assigned provider the clinical health record described in Section I, Item 4 above via a web based application.
6. The clinical health record will only be made available to a provider who is authenticated and registered to utilize the web based application. The CONTRACTOR shall provide two (2) full time employees to assist the provider in the authentication and registration process. Upon completion of the authentication and registration process, the provider will be able to access the clinical health record.
7. The CONTRACTOR shall maintain a log of each clinical health record that is transmitted to DCS and/or the assigned providers and will be made available upon request.
8. Responsibilities of TENNCARE are listed below:
 - a. Provision of Data and Program Information: TENNCARE shall arrange for the following data to be provided. All data provided on a weekly basis shall be provided no later than Wednesday of the week following the data collection.
 - b. Eligibility files daily that meet the requirements of the HIPAA Standard Transaction for Eligibility (270/271).
 - c. Medical claim encounter data from all participating MCOs shall be provided on a weekly basis. Each weekly transmission will include all claims processed by each MCO for the prior period.
 - d. Pharmacy claim encounter data shall be provided on a weekly basis. Each transmission will include all pharmacy claims processed for the prior period.
 - e. Provider file shall be provided on a monthly basis and include the National Provider Identified for each provider; however, TENNCARE shall not be responsible for linking each provider to a common provider number for said file.



Amendment 33 (cont.)

II. Payment Terms and Conditions

1. Payment Methodology. The CONTRACTOR shall be compensated based on the payment rates herein for services authorized by the State:

Description	Implementation Fee	Monthly
Clinical Health Record Report Development	\$189,000	
Monthly Service Fee		\$99,000



Amendment 33 (cont.)

All of the provisions of the original Contract not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective January 1, 2014.

The State is not bound by this Amendment until it is signed by the contract parties and approved by appropriate officials in accordance with applicable Tennessee laws and regulations (depending upon the specifics of this Contract, said officials may include, but are not limited to, the Commissioner of Finance and Administration, the Commissioner of Human Resources, and the Comptroller of the Treasury).

The CONTRACTOR, by signature of this Amendment, hereby affirms that this Amendment has not been altered and therefore represents the identical document that was sent to the CONTRACTOR by TENNCARE.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

VOLUNTEER STATE HEALTH PLAN, INC.

BY: Larry B. Martin/co
Larry B. Martin
Commissioner

BY: Scott C. Pierce
Scott C. Pierce
President & CEO VSHP

DATE: 12/5/2013

DATE: 11-19-13

CONTRACT SUMMARY SHEET



RFS Number:	31866-00026	Edison #	29635	Contract Number:	FA-02-14632-32
State Agency:	Department of Finance and Administration			Division:	Bureau of TennCare
Contractor				Contract Identification Number	
VSHP (TennCare Select)				<input type="checkbox"/> V- <input type="checkbox"/> C-	Edison Vendor #0000071694

Service Description

Managed Care Organization / Medically Necessary Health Care Services to the TennCare/Medicaid Population

Contract Begin Date	Contract End Date
7/1/2001	12/31/2014

Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66	4A2	134	11	<input type="checkbox"/> STARS		
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)	
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$ 18,599,868.48	
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$ 33,079,942.80	
2004	\$ 25,125,990.72	\$ 38,364,165.90			\$ 63,490,156.62	
2005	\$ 58,007,447.00	\$ 58,007,447.00			\$ 116,014,894.00	
2006	\$ 87,748,111.00	\$ 87,748,111.00			\$ 175,496,222.00	
2007	\$ 87,748,111.00	\$ 87,748,111.00			\$ 175,496,222.00	
2008	\$ 72,610,000.00	\$ 127,390,000.00			\$ 200,000,000.00	
2009	\$ 72,610,000.00	\$ 127,390,000.00			\$ 200,000,000.00	
2010	\$ 100,882,479.00	\$ 304,024,121.00			\$ 404,906,600.00	
2011	\$ 131,085,619.00	\$ 312,820,981.00			\$ 443,906,600.00	
2012	\$ 149,893,942.00	\$ 294,012,658.00			\$ 443,906,600.00	
2013	\$ 150,102,578.00	\$ 293,804,022.00			\$ 443,906,600.00	
2014	\$ 153,147,777.00	\$ 290,758,823.00			\$ 443,906,600.00	
Total:	\$ 1,111,503,115.35	\$ 2,051,207,190.55			\$ 3,162,710,305.90	

CFDA#	93.778 Title XIX Dept. of Health & Human Svcs.	Check the box ONLY if the answer is YES:	
State Fiscal Contract		Is the Contractor a SUBRECIPIENT? (per OMB A-133)	
Name:	Casey Dungan	Is the Contractor a Vendor? (per OMB A-133)	
Address:	310 Great Circle Road Nashville, TN	Is the Fiscal Year Funding STRICTLY LIMITED?	
Phone:	(615)507-6482		
Procuring Agency Budget Officer Approval Signature		Is the Contractor on STARS?	
Casey Dungan		Is the Contractor's FORM W-9 ATTACHED?	
		Is the Contractor's Form W-9 Filed with Accounts?	

COMPLETE FOR ALL AMENDMENTS (only)			Funding Certification
	Base Contract & Prior Amendments	This Amendment ONLY	Funding Certification (certification, required by T.C.A., § 9-4-5113, that there is a balance in the appropriation from which the obligated expenditure is required to be paid that is not otherwise encumbered to pay obligations previously incurred)
CONTRACT END DATE:	12/31/2014		
FY: 2002	\$ 18,599,868.48		
FY: 2003	\$ 33,079,942.80		
FY: 2004	\$ 63,490,156.62		
FY: 2005	\$ 116,014,894.00		
FY: 2006	\$ 175,496,222.00		
FY: 2007	\$ 175,496,222.00		
FY: 2008	\$ 200,000,000.00		
FY: 2009	\$ 200,000,000.00		
FY: 2010	\$ 404,906,600.00		
FY: 2011	\$ 443,906,600.00		
FY: 2012	\$ 443,906,600.00		
FY: 2013	\$ 443,906,600.00		
FY: 2014	\$ 443,906,600.00		
Total:	\$ 3,162,710,305.90		



AMENDMENT NUMBER 32

**AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.**

CONTRACT NUMBER: FA-02-14632-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as specified below.

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. Section 1 shall be amended by adding the following definitions:

Individuals with Limited English Proficiency (LEP) – Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand the English language.

Oral Interpretation - Is the act of listening to something in one language (source language) and orally translating it into another language (target language).

Vital Documents - Vital Documents may include, but are not limited to, consent and complaint forms, intake and application forms with the potential for important consequences, notices pertaining to the reduction, denial, delay, suspension or termination of services, certain critical outreach documents (i.e. case management and Population Health documents) and any other documents designated by the State. At a minimum, all Vital Documents shall be available in the Spanish language.

Written Translation - Is the replacement of a written text from one language (source language) into an equivalent written text in another language (target language).

2. Section 1 shall be amended by deleting the definition for “Vital MCO Documents”.

3. Section 1 shall be amended by deleting and replacing the following definitions:

Eligible Individual – With respect to Tennessee’s Money Follows the Person Rebalancing Demonstration (MFP) and pursuant to Section 6071(b)(2) of the Deficit Reduction Act of 2005 (DRA), (Pub. L. 109-171 (S. 1932)) (Feb. 8, 2006) as amended by Section 2403 of the Patient Protection and Affordable Care Act of 2010 (ACA), (Pub. L. 111-148) (May 1, 2010), the State’s approved MFP Operational Protocol and TennCare Rules, a member who qualifies to participate in MFP. Such person, immediately before beginning participation in the MFP demonstration project, shall:



Amendment 32 (cont.)

1. Reside in a Nursing Facility (NF) or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) and have resided for a period of not less than ninety (90) consecutive days in a Qualified Institution.
 - a. Inpatient days in an institution for mental diseases (IMDs) which includes Psychiatric Hospitals and Psychiatric Residential Treatment Facilities (PRTF) may be counted only to the extent that Medicaid reimbursement is available under the State Medicaid plan for services provided by such institution. Medicaid payments may only be applied to persons in IMDs who are over 65 or under 21 years of age.
 - b. Any days that an individual resides in a Medicare certified Skilled Nursing Facility (SNF) on the basis of having been admitted solely for purposes of receiving post-hospital short-term rehabilitative services covered by Medicare shall not be counted for purposes of meeting the ninety (90)-day minimum stay in a Qualified Institution established under ACA.
 - c. Short-term continuous care in a nursing facility, to include Level 2 nursing facility reimbursement, for episodic conditions to stabilize a condition rather than admit to hospital or to facilitate hospital discharge, and inpatient rehabilitation facility services reimbursed by the CONTRACTOR (i.e., not covered by Medicare) as a cost-effective alternative (see Section 2.6.5) and provided in a Qualified Institution shall be counted for purposes of meeting the ninety (90) day minimum stay in a Qualified Institution established under ACA.
2. Be eligible for and receive Medicaid benefits for inpatient services furnished by the nursing facility or ICF/IID for at least one (1) day. For purposes of this Agreement, an Eligible Individual must reside in a nursing facility and be enrolled in CHOICES Group I for a minimum of one (1) day and must be eligible to enroll and transition seamlessly into CHOICES Group 2 without delay or interruption.
3. Meet nursing facility or ICF/IID level of care, as applicable, and, but for the provision of ongoing CHOICES HCBS, continue to require such level of care provided in an inpatient facility.

Home and Community-Based Services (HCBS) – Services that are provided pursuant to a Section 1915(c) waiver or the CHOICES program as an alternative to long-term care institutional services in a nursing facility or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or to delay or prevent placement in a nursing facility. HCBS may also include optional or mandatory services that are covered by Tennessee’s Title XIX state plan or under the TennCare demonstration for all eligible enrollees, including home health or private duty nursing. However, only CHOICES HCBS are eligible for Consumer Direction. CHOICES HCBS do not include home health or private duty nursing services or any other HCBS that are covered by Tennessee’s Title XIX state plan or under the TennCare demonstration for all eligible enrollees, although such services are subject to estate recovery and shall be counted for purposes of determining whether a CHOICES member’s needs can be safely met in the community within his or her individual cost neutrality cap.

Long-Term Care (LTC) – The services of a nursing facility (NF), an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or Home and Community-Based Services (HCBS). These services may also be called Long-Term Services and Supports (LTSS).

Money Follows the Person Rebalancing Demonstration (MFP) – A federal grant established under the Deficit Reduction Act and extended under the Affordable Care Act that will assist Tennessee in transitioning Eligible Individuals from a nursing facility or ICF/IID into a Qualified Residence in the



community and in rebalancing long-term care expenditures. The grant provides enhanced match for HCBS provided during the first 365 days of community living following transition.

Qualified Institution – With respect to Tennessee’s MFP Rebalancing Demonstration, and pursuant to Section 6071(b)(3) of the DRA, a hospital, nursing facility, or ICF/IID.

1. An institution for mental diseases (IMDs) which includes Psychiatric Hospitals and Psychiatric Residential Treatment Facilities (PRTF) shall be a Qualified Institution only to the extent that Medicaid reimbursement is available under the State Medicaid plan for services provided by such institution. Medicaid payments may only be applied to persons in IMDs who are over 65 or under 21 years of age.
2. Any days that an individual resides in a Medicare certified Skilled Nursing Facility (SNF) on the basis of having been admitted solely for purposes of receiving post-hospital short-term rehabilitative services covered by Medicare shall not be counted for purposes of meeting the ninety (90)-day minimum stay in a Qualified Institution established under the Affordable Care Act.

4. Section 2.2.3 shall be deleted and replaced as follows:

2.2.3 If the CONTRACTOR is part of a health maintenance organization holding company system as defined by TCA 56-11-101(b)(5), the CONTRACTOR agrees to comply with the Insurance Holding Company System Act of 1986 as set forth in TCA 56-11-101 et seq. The CONTRACTOR agrees to comply with the requirements of TCA 56-11-101 et seq. whether the CONTRACTOR is domiciled in Tennessee or is a foreign health maintenance organization subject to registration requirements and standards adopted by statute or regulation in the jurisdiction of its domicile that are substantially similar to this contained in TCA 56-11-101 et seq. If the CONTRACTOR is a foreign domiciled health maintenance organization, the manner in which the CONTRACTOR shall comply with the requirements of TCA 56-11-101 et seq. are outlined in a Memorandum of Understanding between the CONTRACTOR and the Tennessee Department of Commerce and Insurance, TennCare Oversight Division, which is incorporated herein by reference. The information disclosed or filed in accordance with the requirements of TCA 56-11-101 et seq. shall be considered Confidential Information pursuant to TCA 56-11-108.

5. Section 2.4.6.1 shall be amended by adding a new sentence to the end of the existing text as follows:

2.4.6.1 The CONTRACTOR shall receive, process, and update outbound 834 enrollment files from TENNCARE. Enrollment data shall be updated or uploaded systematically to the CONTRACTOR’s eligibility/enrollment database(s) within twenty-four (24) hours of receipt from TENNCARE. Any outbound 834 transactions which fail to update/load systematically must be manually updated within twenty-four (24) hours of receipt. The CONTRACTOR shall report to TENNCARE, in a form and format to be provided by TENNCARE, outbound 834 transactions that are not processed within these time frames and include information regarding when the transactions were completed. Any transactions that are not updated/loaded within twenty-four (24) hours of receipt from TENNCARE and/or persistent issues with high volumes of transitions that require manual upload may require the CONTRACTOR to initiate a Corrective Action Plan for resolution of the issues preventing compliance. If the CONTRACTOR has reason to believe they may not meet this requirement based on unusual circumstances, the CONTRACTOR must notify TENNCARE and TENNCARE may make an exception without requiring a Corrective Action Plan.



6. Section 2.6.1.5.4 shall be amended by adding new Section 2.6.1.5.4.1 through 2.6.1.5.4.1.2 as follows:

2.6.1.5.4.1 The CONTRACTOR shall authorize and/or reimburse short-term NF stays for Group 2 and Group 3 members only when (1) the member is enrolled in CHOICES Group 2 or 3, as applicable, and receiving HCBS upon admission; (2) the member meets the nursing facility level of care in place at the time of admission; (3) the member's stay in the facility is expected to be less than ninety (90) days; and (4) the member is expected to return to the community upon its conclusion. The CONTRACTOR shall monitor all short-term NF stays for Group 2 and Group 3 members and shall ensure that the member is transitioned from Group 2 or Group 3, as applicable, to Group 1 at any time a) it is determined that the stay will not be short-term or the member will not transition back to the community; and b) prior to exhausting the ninety (90)-day short-term NF benefit covered for CHOICES Group 2 and Group 3 members.

2.6.1.5.4.1.1 The ninety (90) day limit shall be applied on a per admission (and not a per year) basis. A member may receive more than one short-term stay during the year. However, the CONTRACTOR shall be responsible for carefully reviewing any instance in which a member receives multiple short-term stays during the year or across multiple years, including a review of the circumstances which resulted in each nursing facility admission, and shall evaluate whether the services and supports provided to the member are sufficient to safely meet his needs in the community such that transition back to CHOICES Group 2 or Group 3 (as applicable) is appropriate.

2.6.1.5.4.1.2 Upon request, the CONTRACTOR shall provide to TENNCARE a member-by-member status for each Group 2 and Group 3 member utilizing the short-term NF stay benefit, including but not limited to the name of each Group 2 and Group 3 member receiving short-term NF services, the NF in which s/he currently resides, the date of admission for short-term stay, and the anticipated date of discharge back to the community.

7. Section 2.6.2.3 shall be amended by deleting and replacing the reference "ICF/MR" with "ICF/IID", replacing the reference "Intermediate Care Facility for the Mentally Retarded (ICF/MR)" with "Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)" and deleting the phrase "(i.e., mental retardation)".

8. Section 2.7.4.1.12 shall be amended by adding the phrase " , at least annually," as follows:

2.7.4.1.12 Education, at least annually, for members and caregivers about identification and reporting of suspected abuse and neglect;

9. Section 2.7.4.2.1 shall be deleted and replaced as follows:

2.7.4.2.1 The Annual Community Outreach Plan shall be written in accordance with guidance prepared by TENNCARE. It shall include, but is not limited to: all proposed community/health education events related to TENNderCare; all proposed community/health education events unrelated to TENNderCare; and a process for evaluating the benefits of the events. An Annual Evaluation of the Plan shall be due no later than ninety (90) days following the end of a calendar year in a format approved by TENNCARE.



10. Section 2.7.4.2 shall be amended by adding a new Section 2.7.4.2.4 as follows:

2.7.4.2.4 The CONTRACTOR shall submit an *Annual Community Outreach Evaluation* of the approved Annual Community Outreach Plan no later than ninety (90) days following the end of a calendar year. The Evaluation shall include, but is not limited to, an assessment of the events that were conducted in the previous year as well as of the objectives that were identified in the CONTRACTOR'S Community Outreach Plan.

11. Section 2.7.6.3.3.5 shall be amended by deleting and replacing the phrase "ten (10) ug/dL" with the phrase "five (5) ug/dL" as follows:

2.7.6.3.3.5 Appropriate laboratory tests (including lead toxicity screening appropriate for age and risk factors). All children are considered at risk and shall be screened for lead poisoning. All children shall receive a screening blood lead test at twelve (12) and twenty-four (24) months of age. Children between the ages of thirty-six (36) months and seventy-two (72) months of age shall receive a screening blood lead test if they have not been previously screened for lead poisoning. A blood lead test shall be used when screening Medicaid-eligible children. A blood lead test equal to or greater than five (5) ug/dL obtained by capillary specimen (finger stick) shall be confirmed by using a venous blood sample; and

12. Section 2.7.6.4.7.1 shall be deleted and replaced as follows:

2.7.6.4.7.1 The CONTRACTOR shall provide follow up for elevated blood lead levels. Determining elevated blood levels requiring follow-up shall be in accordance with current CDC guidelines. Elevated blood lead follow up guidelines include follow up blood tests and investigations to determine the source of lead, when indicated.

13. Section 2.8.2.1.1 shall be deleted and replaced as follows:

2.8.2.1.1 **Level 0-** The members eligible to participate at this Level shall be determined by predictive modeling to meet ALL of the following criteria: no identified health risks; no identified chronic conditions [as identified by the Chronic Condition tool created by the Agency for Healthcare Research and Quality's (AHRQ) HCUP database]; and no indication of pregnancy; or no claims history.

14. Section 2.8.4.6 shall be amended by deleting and replacing the reference from "Sections 2.8.2.3 and 2.8.2.3.1" to "Sections 2.8.2.2 and 2.8.2.2.1".

15. Section 2.8.11 shall be amended by adding a new Section 2.8.11.5 as follows:

2.8.11.5 The CONTRACTOR shall submit at the beginning of each quarter, through the current secure system, a list in Comma Separated Value (CSV) format consisting of the name, ID, DOB, stratification or risk level and dates of eligibility for level for all MCO members.



16. Section 2.8.13 through 2.8.13.6 shall be deleted and replaced as follows:

2.8.13 Milestones for the Sixth Month (January 1 to July 1, 2013) Transition Period from Disease Management to Population Health

2.8.13.1 The CONTRACTOR shall by July 1, 2013 have operationalized Population Health to provide all minimum interventions to enrollees who are not participating in a medical home lock in project, in the appropriate programs.

17. Section 2.9.6.2.3.4 shall be deleted and replaced as follows:

2.9.6.2.3.4 As part of the intake visit, TENNCARE or its designee shall: (1) document and confirm the applicant's current address and phone number(s); (2) provide general CHOICES education and information, as specified by TENNCARE, and assist in answering any questions the applicant may have; (3) provide information about estate recovery; (4) complete Medicaid and level of care (i.e., PAE) applications and provide assistance, as necessary, in gathering documentation needed by the State to determine TennCare eligibility; (5) provide choice counseling and facilitate the selection of an MCO by the applicant or his/her representative; (6) for applicants seeking enrollment in CHOICES Group 1 or Group 2, provide information regarding freedom of choice of nursing facility versus CHOICES HCBS, both verbally and in writing, and obtain a Freedom of Choice form signed and dated by the applicant or his/her representative; (7) provide detailed information and obtain signed acknowledgement of understanding regarding a CHOICES member's responsibility with respect to payment of patient liability amounts, including, as applicable, the potential consequences for non-payment of patient liability which may include loss of the member's current nursing facility or CBRA provider or MCO, disenrollment from CHOICES, and to the extent the member's eligibility is dependent on receipt of long-term care services, possible loss of eligibility for TennCare; (8) for applicants who want to receive NF services, provide information regarding the completion of all PASRR requirements prior to nursing facility admission and conduct the level I PASRR screening; (9) for applicants who are seeking CHOICES HCBS: (a) conduct a risk assessment in accordance with protocols developed by TENNCARE and discuss with the applicant identified risks of receiving care in the home or community-based setting, the consequences of such risks, and strategies to mitigate the identified risks; and (b) provide information regarding consumer direction and obtain signed documentation of the applicant's interest in participating in consumer direction; and (10) provide information regarding next steps in the process including the need for approval by TENNCARE to enroll in CHOICES and the functions of the CONTRACTOR, including that the CONTRACTOR will develop and approve a plan of care.

18. Section 2.9.6.2.3.7 shall be amended by adding a new phrase as follows:

2.9.6.2.3.7 TENNCARE or its designee will make available to the CONTRACTOR the documentation from the intake visit, including but not limited to the member's current address and phone number(s), the member's level of care and needs assessment, the assessment of the member's existing natural support system, the member's risk assessment and documentation of the discussion regarding identified risk and mitigation strategies.



19. Section 2.9.6.3.9 shall be deleted and replaced as follows:

2.9.6.3.9 As part of the face-to-face intake visit, the care coordinator shall: (1) document and confirm the applicant's current address and phone number(s) and assist the member in updating his or her address with DHS or the Social Security Administration, if applicable; (2) provide general CHOICES education and information, as specified by TENNCARE, to the member and assist in answering questions the member may have; (3) provide information about estate recovery; (4) provide assistance, as necessary, in gathering documentation needed by DHS to determine categorical/financial eligibility for LTC; (5) for members seeking enrollment in CHOICES Group 1 or Group 2, provide information regarding freedom of choice of nursing facility versus CHOICES HCBS, both verbally and in writing, and obtain a Freedom of Choice form signed and dated by the member or his/her representative; (6) provide detailed information and signed acknowledgement of understanding regarding a CHOICES member's responsibility with respect to payment of patient liability amounts, including, as applicable, the potential consequences for non-payment of patient liability which may include loss of the member's current nursing facility or CBRA provider or MCO, disenrollment from CHOICES, and to the extent the member's eligibility is dependent on receipt of long-term care services, possible loss of eligibility for TennCare; and (7) for members who want to receive nursing facility services, provide information regarding the completion of all PASRR requirements prior to nursing facility admission and conduct the level I PASRR screening; (8) for members who are seeking CHOICES HCBS, the care coordinator, shall: (a) conduct a risk assessment using a tool and protocol specified by TENNCARE and shall develop, as applicable, a risk agreement that shall be signed and dated by the member or his/her representative and which shall document identified risks to the member, the consequences of such risks, strategies to mitigate the identified risks, and the member's decision regarding his/her acceptance of risk, and which shall also be signed by the care coordinator, attesting that such risks and strategies have been discussed with the member or his/her representative prior to their decision to accept such risk; and (b) provide information regarding consumer direction and obtain written confirmation of the member's decision regarding participation in consumer direction; (9) for members seeking enrollment in Group 2, make a determination regarding whether the person's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care, and provide explanation to the member regarding the individual cost neutrality cap, including that a change in needs or circumstances that would result in the cost neutrality cap being exceeded or that would result in the CONTRACTOR's inability to safely and effectively meet the member's needs in the community and within the cost neutrality cap may result in the member's disenrollment from CHOICES Group 2, in which case, the member's care coordinator will assist with transition to a more appropriate care delivery setting; (10) for members seeking enrollment in Group 3, provide explanation to the member regarding the fifteen thousand dollar (\$15,000) expenditure cap and make a determination whether the member's needs can be safely met within the array of services and supports that would be available if the applicant was enrolled in CHOICES Group 3, including CHOICES HCBS up to the expenditure cap of \$15,000, non-CHOICES HCBS available through TennCare (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers; and (11) for all members, using current information regarding the CONTRACTOR's network, provide information regarding choice of contract providers, subject to the provider's availability and willingness to timely deliver services, and obtain signed documentation of the member's choice of contract providers.



20. Section 2.9.6.3.20 shall be amended by adding a new Section 2.9.6.3.20.2 and renumbering the remaining Section accordingly, including any references thereto:

2.9.6.3.20.2 Notwithstanding the phone number in the 834 file, for purposes of the EVV system (see Section 2.9.6.12.5.), the CONTRACTOR shall use the member's phone number or appropriate alternative phone number as confirmed during the intake visit (see Section 2.9.6.3.9.) and updated (as applicable) during subsequent care coordination contacts (see Section 2.9.6.9.2.1.5), through EVV alert monitoring or other member contacts for all HCBS that will be logged into the EVV system.

21. The renumbered Section 2.9.6.3.20. shall be amended by adding a new Section 2.9.6.3.20.11 as follows:

2.9.6.3.20.11 Upon receiving notification from TENNCARE that a member's eligibility has ended, the CONTRACTOR shall within two (2) business days notify all providers of ongoing HCBS that the member's CHOICES eligibility has ended, which may be accomplished by notification in the EVV system. Such notification shall not be provided in advance of the actual end date of member's CHOICES eligibility, as a prospective end date could be extended.

22. Section 2.9.6.6.2.4 shall be deleted and replaced as follows:

2.9.6.6.2.4 The plan of care developed for CHOICES members in Groups 2 and 3 prior to initiation of CHOICES HCBS shall at a minimum include: (1) pertinent demographic information regarding the member including the member's current address and phone number(s), the name and contact information of any representative and a list of other persons authorized by the member to have access to health care (including long-term care) related information and to assist with assessment, planning, and/or implementation of health care (including long-term care) related services and supports; (2) care, including specific tasks and functions, that will be performed by family members and other caregivers; (3) home health, private duty nursing, and long-term care services the member will receive from other payor sources including the payor of such services; (4) home health and private duty nursing that will be authorized by the CONTRACTOR, except in the case of persons enrolled in CHOICES Group 2 on the basis of Immediate Eligibility who shall have access to services beyond the limited package of CHOICES HCBS (see Section 2.6.1.5.3) only upon determination of categorical and financial eligibility for TennCare; (5) CHOICES HCBS that will be authorized by the CONTRACTOR, including the amount, frequency, duration, and scope (tasks and functions to be performed) of each service to be provided, the schedule at which such care is needed, and the phone number(s) that will be used to log visits into the EVV system, as applicable; members enrolled in CHOICES Group 2 on the basis of Immediate Eligibility shall have access only to a limited package of CHOICES HCBS (see Section 2.6.1.5.3) pending determination of categorical and financial eligibility for TennCare however all identified needed services shall be listed in the plan of care; (6) a detailed back-up plan for situations when regularly scheduled HCBS providers are unavailable or do not arrive as scheduled; the back-up plan may include paid and unpaid supports and shall include the names and telephone numbers of persons and agencies to contact and the services provided by listed contacts; the CONTRACTOR shall assess the adequacy of the back-up plan; and (7) for CHOICES Group 2 members, the projected TennCare monthly and annual cost of home health and private duty nursing identified in (4) above, and the projected monthly and annual cost of



CHOICES HCBS specified in (5) above, and for CHOICES Group 3 members, the projected total cost of CHOICES HCBS specified in (5) above, excluding the cost of minor home modifications.

23. Section 2.9.6.6.2.5.6 and 2.9.6.6.2.5.7 shall be deleted and replaced as follows and Section 2.9.6.6.2.5.8 shall be deleted in its entirety. The remaining Section 2.9.6.6.2.5 shall be renumbered accordingly, including any references thereto.

2.9.6.6.2.5.6 A person-centered statement of goals, objectives and desired health, functional and quality of life outcomes for the member and how CHOICES services are intended to help the member achieve these goals;

2.9.6.6.2.5.7 Description of other services that will be provided to the member, including (1) covered physical health services, including population health services, that will be provided by the CONTRACTOR to help the member maintain or improve his or her physical health status or functional abilities and maximize independence; (2) covered behavioral health services that will be provided by the CONTRACTOR to help the member maintain or improve his or her behavioral health status or functional abilities and maximize independence; (3) other psycho/social support services and assistance needed in order to ensure the member's health, safety and welfare, and as applicable, to delay or prevent the need for more expensive institutional placement; and (4) any non-covered services including services provided by other community resources, including plans to link the member to financial assistance programs including but not limited to housing, utilities and food as needed;

24. The renumbered Section 2.9.6.6.2.5.12 shall be deleted and replaced as follows:

2.9.6.6.2.5.12 Any steps the member and/or representative should take in the event of an emergency that differ from the standard emergency protocol;

2.9.6.6.2.5.12.1 Planning what to do during an emergency shall include, but may not be limited to the following:

2.9.6.6.2.5.12.1.1 Developing an emergency plan;

2.9.6.6.2.5.12.1.2 Creating a plan to have shelter in place when appropriate;

2.9.6.6.2.5.12.1.3 Creating a plan to get to another safe place when appropriate; and

2.9.6.6.2.5.12.1.4 Identifying, when possible, two ways out of every room in case of fire.

2.9.6.6.2.5.12.2 Identify any additional steps the member and/or representative should take in the event of an emergency.



25. **Section 2.9.6.6.2.6 shall be amended by adding additional language as follows:**
- 2.9.6.6.2.6 The member's care coordinator/care coordination team shall ensure that the member reviews, signs and dates the plan of care as well as any substantive updates, including but not limited to any changes in the amount, duration or type of HCBS that will be provided. The care coordinator shall also sign and date the plan of care, along with any substantive updates. The plan of care shall be updated and signed by the member and the care coordinator annually and any time the member experiences a significant change in needs or circumstances (see Section 2.9.6.9.2.1.16).
26. **Section 2.9.6.6.2.6 shall be amended by adding a new Section 2.9.6.6.2.6.4 which shall read as follows:**
- 2.9.6.6.2.6.4 Instances in which a member's signature is not required are limited to: 1) member-initiated schedule changes to the POC that do not alter the level of services (i.e. the amount, duration or type of services) detailed in the current POC for the member; 2) changes in the provider agency that will deliver services that do not alter the level of services (i.e. the amount, duration or type of services) detailed in the current POC for the member; however, all schedule changes must be member-initiated; 3) changes in the member's current address and phone number(s) or the phone number(s) that will be used to log visits into the EVV system; or 4) instances as permitted pursuant to TennCare policies and protocols. Documentation of such changes shall be maintained in the member's records.
27. **Section 2.9.6.8.26.4 and 2.9.6.8.26.4.1 shall be deleted in their entirety and the remaining Section 2.9.6.8 shall be renumbered accordingly, including any references thereto.**
28. **Section 2.9.6.9.2.1 shall be amended by adding a new Section 2.9.6.9.2.1.5 as follows and renumbering the remaining Section accordingly, including any references thereto.**
- 2.9.6.9.2.1.5 Document and confirm the applicant's current address and phone number(s) or appropriate alternative phone number(s) that the member's service provider will use to call in/out for the purpose of logging visits into the EVV system, and assist the member in updating his or her address with DHS or the Social Security Administration, if applicable;
29. **Section 2.9.6.9.4.3.7 shall be amended by deleting the phrase "or Group 3".**
30. **Section 2.9.6.9.4.3 shall be amended by adding a new Section 2.9.6.9.4.3.8 as follows and renumbering the remaining Section accordingly, including any references thereto.**
- 2.9.6.9.4.3.8 Members in CHOICES Group 3 shall be contacted by their care coordinator at least quarterly (more frequently when appropriate based on the member's needs and/or request which shall be documented in the plan of care). Such contacts shall be either in person or by telephone with an interval of at least sixty (60) days between contacts. These members shall be visited in their residence face-to-face by their care coordinator at least semi-annually (more frequently when appropriate based on the member's needs and/or request which shall be documented in the plan of care) with an interval of at least one hundred-twenty (120) days between visits.



31. Section 2.9.6.10.16 shall be deleted and replaced as follows:

2.9.6.10.16 If at anytime abuse or neglect is suspected, the member’s care coordinator or the FEA shall report the allegations to the CONTRACTOR within 24 hours in accordance with the CONTRACTOR’s abuse and neglect plan protocols. The notification shall include at a minimum: the member name; date of allegation reported and/or identified; description of issue; measures taken to mitigate risk; status of reporting to CPS or APS, as appropriate. If the allegation is in reference to a worker or representative, the FEA shall contact the member/representative to immediately release the worker or representative from his/her duties until the investigation is complete. The FEA shall notify the CONTRACTOR regarding this communication with the member/representative and the member or representative’s decision. The care coordinator shall work with the member to find a new representative and the FEA shall work with the member to find a suitable replacement worker, if applicable. If the allegations are substantiated as a result of the investigation, the representative or worker shall no longer be allowed to participate in the CHOICES program as a representative or worker. If the investigation is inconclusive, the member may elect to retain the worker or representative. The member’s care coordinator, with appropriate assistance from the FEA, shall make any updates to the member’s plan of care and/or risk assessment/risk agreement deemed necessary to help ensure the member’s health and safety, and shall provide, at least annually, education of the member and his/her representative of the risk of, and signs and symptoms of, abuse and neglect. The CONTRACTOR may initiate action to involuntary disenroll the member from consumer direction at any time the CONTRACTOR feels that the member’s decisions or actions constitute unreasonable risk such that the member’s needs can no longer be safely and effectively met in the community while participating in consumer direction.

32. Section 2.9.6.11.6.2 through 2.9.6.11.6.4 shall be deleted and replaced as follows and the remaining Section 2.9.6.11.6 shall be renumbered accordingly, including any references thereto.

2.9.6.11.6.2 Each CHOICES Group 2 member shall be factored into the weighted caseload and staffing ratio calculations utilizing an acuity level of two and one-half (2.5);

2.9.6.11.6.3 Each CHOICES Group 3 member shall be factored into the weighted caseload and staffing ratio calculations utilizing an acuity level of one and three quarters (1.75);

2.9.6.11.6.4 Using the delineated acuity factors, the following provides examples of the composition of caseloads with a weighted value of 125:

CHOICES Group 1	CHOICES Group 2	CHOICES Group 3	Total CHOICES Members on Caseload
125	0		125
100	10		110
50	9	30	89
25	26	20	71
0	50		50



2.9.6.11.6.5 Using the delineated acuity factors, the following delineates the composition of caseloads with a weighted value of 175:

CHOICES Group 1	CHOICES Group 2	CHOICES Group 3	Total CHOICES Members on Caseload
175	0		175
125	10		110
75	19	30	124
50	36	20	106
0	70		70

33. Section 2.9.6.12 shall be amended by adding new Sections 2.9.6.12.3 through 2.9.6.12.4.4 as follows and renumbering the remaining Section accordingly, including any references thereto.

2.9.6.12.3 The CONTRACTOR shall oversee its selected EVV vendor to ensure the EVV system operates in compliance with this Agreement, and with policies and protocols established by TENNCARE. The CONTRACTOR shall notify TENNCARE within five (5) business days of the identification of any issue affecting EVV system operation which impacts the CONTRACTOR's performance of this Agreement, including actions that will be taken by the CONTRACTOR to resolve the issue and the specific timeframes within which such actions will be completed.

2.9.6.12.4 The CONTRACTOR shall establish business processes and procedures which shall include a standard process by which providers may notify the CONTRACTOR of exceptions for which an action by the CONTRACTOR is required for resolution and shall maintain an adequate number of qualified, trained staff to support the operation of the EVV system. These staff will ensure that:

2.9.6.12.4.1 Authorizations as defined pursuant to 2.9.6.2.5.12. are entered into the EVV system timely and accurately, including any changes in such authorizations based on changes in the member's plan of care.

2.9.6.12.4.2 Authorizations provided by the CONTRACTOR outside the EVV system are consistent with authorizations entered by the CONTRACTOR into the EVV system and with the member's currently approved plan of care.

2.9.6.12.4.3 Any actions required by the CONTRACTOR to resolve exceptions in the EVV system, e.g., a change in the service authorization, are completed within three (3) business days so that claims for services can be submitted for payment.

2.9.6.12.4.4 The CONTRACTOR monitors on an ongoing basis and reports to TENNCARE upon request, the total volume of CHOICES HCBS that have been provided but not reimbursed due to issues with the EVV system or due to individual exceptions, and proactively works with providers and the FEA to ensure that issues are corrected and exceptions are resolved as expeditiously as possible and within the timeframes specified above in order to provide payment as appropriate for services delivered.



34. **The renumbered Section 2.9.6.12.5 shall be amended by deleting the phrase “homemaker services”.**
35. **Section 2.9.6.12 shall be amended by adding a new Section 2.9.6.12.7 as follows and renumbering the remaining Section accordingly, including any references thereto.**
- 2.9.6.12.7 Notwithstanding the phone number in the 834 file, the CONTRACTOR shall use the member’s phone number or appropriate alternative phone number as confirmed during the intake visit (see Section 2.9.6.3.9.) and updated (as applicable) during subsequent care coordination contacts (see Section 2.9.6.9.2.1.5.) for all HCBS that will be logged into the EVV system.
36. **Section 2.9.7.1.1 shall be amended by deleting “homemaker,” in the first sentence.**
37. **Section 2.9.8 shall be deleted and replaced as follows:**
- 2.9.8 **Money Follows the Person (MFP) Rebalancing Demonstration**
- 2.9.8.1 General
- 2.9.8.1.1 The MFP Rebalancing Demonstration provisions set forth in this Agreement, including but not limited to this Section 2.9.8 and MFP reporting requirements in Section 2.30 shall not apply to TennCare Select unless TENNCARE notifies the CONTRACTOR otherwise. Should TENNCARE assign enrollees to TennCare Select in accordance with this Contract, including Section 2.4.4.3.4, to serve as a backup if other MCOs fail or are deemed by TENNCARE to have inadequate MCO capacity, TENNCARE will notify TennCare Select of the applicability of the MFP provisions.
- 2.9.8.1.2 The CONTRACTOR shall, in accordance with this Agreement and federal and State laws, regulations, policies and protocols, assist Eligible Individuals living in a Qualified Institution in transitioning to a Qualified Residence in the community under the State’s MFP Rebalancing Demonstration (MFP).
- 2.9.8.1.3 Eligible Individuals transitioning to a Qualified Residence in the community and consenting to participate in MFP shall be transitioned from CHOICES Group 1 into CHOICES Group 2 pursuant to TennCare policies and protocols for Nursing Facility-to-community transitions and shall also be enrolled into MFP. For persons enrolled in CHOICES who are also participating in MFP, the CONTRACTOR shall comply with all applicable provisions of this Agreement pertaining to the CHOICES program. This section sets forth additional requirements pertaining to the CONTRACTOR’s responsibilities specifically as it relates to MFP.
- 2.9.8.1.4 For CHOICES Group 1 members not eligible to participate in MFP or who elect not to participate in MFP, the CONTRACTOR shall nonetheless facilitate transition to the community as appropriate and in accordance with 2.9.6.8.
- 2.9.8.1.5 The CONTRACTOR shall not delay a CHOICES Group 1 member’s transition to the community in order to meet the ninety (90)-day minimum stay in a Qualified Institution established under ACA and enroll the person into MFP.



2.9.8.2 Identification of MFP Participants

- 2.9.8.2.1 The CONTRACTOR shall identify members who may have the ability and/or desire to transition from a nursing facility to the community in accordance with Section 2.9.6.8.
- 2.9.8.2.2 The CONTRACTOR shall assess all nursing facility residents transitioning from the NF to CHOICES Group 2 for participation in MFP. This includes CHOICES Group 1 members referred for transition, as well as nursing facility residents referred for CHOICES who are not yet enrolled in CHOICES Group 1 but may be determined eligible for Group 1, and who have expressed a desire to move back into the community. However, the resident must actually be enrolled into Group 1 in order to qualify for MFP.
- 2.9.8.2.3 Members may only elect to participate in MFP and the CONTRACTOR may only enroll a member into MFP prior to the member's transition from the nursing facility to the community. Members will not be eligible to enroll in MFP if they have already transitioned out of the nursing facility.

2.9.8.3 Eligibility/Enrollment into MFP

- 2.9.8.3.1 Member participation in MFP is voluntary. Members may deny consent to participate in MFP or may withdraw consent to participate in MFP at any time without affecting their enrollment in CHOICES.
- 2.9.8.3.2 If a member withdraws from MFP, he cannot participate in MFP again without meeting the eligibility requirements for enrollment into MFP (e.g., following a ninety (90)-day stay in a Qualified Institution).
- 2.9.8.3.3 Only CHOICES Group 1 members who qualify to enroll in CHOICES Group 2 shall be eligible to transition to Group 2 and enroll into MFP.
- 2.9.8.3.4 In addition to facilitating transition from CHOICES Group 1 to CHOICES Group 2 pursuant to Section 2.9.6.8 of this Agreement and TENNCARE's policies and protocols, the CONTRACTOR shall facilitate the enrollment of Eligible Individuals who consent into MFP.
- 2.9.8.3.5 The member's care coordinator or, if the CONTRACTOR elects to use transition teams, a person who meets the qualifications of a care coordinator shall, using information provided by TENNCARE, provide each potential MFP participant with an overview of MFP and answer any questions the participant has. The CONTRACTOR shall have each potential MFP participant or his authorized representative, as applicable, sign an MFP Informed Consent Form affirming that such overview has been provided by the CONTRACTOR and documenting the member's decision regarding MFP participation.
- 2.9.8.3.6 Once a potential MFP participant has consented to participate in MFP, the CONTRACTOR shall notify TENNCARE within two (2) business days via the TENNCARE PreAdmission Evaluation System (TPAES) unless otherwise directed by TENNCARE, and shall maintain supporting documentation as specified by TENNCARE that shall be made available to TENNCARE upon request.
- 2.9.8.3.7 The CONTRACTOR shall verify that each potential MFP participant is an Eligible Individual and shall provide attestation thereof to TENNCARE. The CONTRACTOR shall enter all required data elements into TPAES unless otherwise directed by TENNCARE, and shall



maintain supporting documentation as specified by TENNCARE that shall be made available to TENNCARE upon request.

- 2.9.8.3.8 The CONTRACTOR shall verify that each potential MFP participant will transition into a Qualified Residence in the community and shall provide attestation thereof to TENNCARE. The CONTRACTOR shall enter all required data elements into TPAES unless otherwise directed by TENNCARE and shall maintain supporting documentation as specified by TENNCARE that shall be made available to TENNCARE upon request.
- 2.9.8.3.9 Final determinations regarding whether a member can enroll into MFP shall be made by TENNCARE based on information provided by the CONTRACTOR.
- 2.9.8.3.10 TENNCARE may request and the CONTRACTOR shall submit in a timely manner additional documentation as needed to make such determination. Documentation submitted by the CONTRACTOR may be verified, to the extent practicable, by other information, either prior or subsequent to enrollment in MFP, including eligibility, claims and encounter data.

2.9.8.4 Participation in MFP

- 2.9.8.4.1 The participation period for MFP is 365 days. This includes all days during which the member resides in the community, regardless of whether CHOICES HCBS are received each day. Days are counted consecutively except for days during which the member is admitted to an inpatient facility.
- 2.9.8.4.2 The participation period for MFP does not include any days during which the member is admitted to an inpatient facility.
- 2.9.8.4.3 MFP participation will be “suspended” in the event a member is re-admitted for a short-term inpatient facility stay. Member will not have to re-qualify for MFP regardless of the number of days the member is in the inpatient facility, and shall be re-instated in MFP upon return to a Qualified Residence in the community.
- 2.9.8.4.4 It may take longer than 365 calendar days to complete the 365-day MFP participation period days since a member’s participation period may be interrupted by one or more inpatient facility stays.
- 2.9.8.4.5 For MFP participants, a significant change in circumstances (see 2.9.6.9.2.1.16.) shall include any admission to an inpatient facility, including a hospital, psychiatric hospital, PRTF, nursing facility or Medicare-certified Skilled Nursing Facility. The member’s Care Coordinator shall (pursuant to 2.9.6.2.4) visit the member face-to-face within five (5) business days of any inpatient facility admission and shall assess the member’s needs, conduct a comprehensive needs assessment and update the member’s plan of care, including the member’s Risk Agreement, as deemed necessary based on the member’s needs and circumstances. If the visit is conducted in the inpatient facility, the CONTRACTOR may elect to have someone who meets the qualifications of a Care Coordinator complete the required face-to-face visit and conduct a comprehensive needs assessment, in which case, the qualified individual conducting the face-to-face visit shall coordinate with the member’s Care Coordinator to update the member’s plan of care, including the member’s Risk Agreement, as deemed necessary based on the member’s needs and circumstances.



Amendment 32 (cont.)

- 2.9.8.4.6 The CONTRACTOR shall review the circumstances which resulted in the inpatient facility admission and shall evaluate whether the services and supports provided to the member are sufficient to safely meet his needs in the community such that continued participation in CHOICES Group 2 and in MFP is appropriate.
- 2.9.8.4.7 The CONTRACTOR shall notify TENNCARE within five (5) business days of admission any time a member is admitted to an inpatient facility. Such notification shall be made via TPAES unless otherwise directed by TENNCARE. The CONTRACTOR shall maintain supporting documentation as specified by TENNCARE that shall be made available to TENNCARE upon request.
- 2.9.8.4.7.1 For purposes of MFP, admission for observation (which is not considered inpatient care) shall not be considered admission to an inpatient facility. Nor shall participation in MFP be suspended during observation days.
- 2.9.8.4.8 The CONTRACTOR shall be involved in discharge planning on behalf of any MFP participant admitted to an inpatient facility.
- 2.9.8.4.9 The CONTRACTOR shall notify TENNCARE within two (2) business days when an MFP participant is discharged from a short-term stay in an inpatient facility. Such notification shall include whether the member is returning to the same Qualified Residence in which he lived prior to the inpatient stay, or a different residence which shall also be a Qualified Residence. Such notification shall be made via TPAES unless otherwise directed by TENNCARE. The CONTRACTOR shall maintain supporting documentation as specified by TENNCARE that shall be made available to TENNCARE upon request.
- 2.9.8.4.10 If at any time during the member's participation in MFP, the member changes residences, including instances in which the change in residences occurs upon discharge from an inpatient facility stay, the CONTRACTOR shall: 1) notify TENNCARE within two (2) business days of the change in residence; 2) verify that the new residence is a Qualified Residence; and 3) provide attestation thereof to TENNCARE. The CONTRACTOR shall enter all required data elements into TPAES unless otherwise directed by TENNCARE, and shall maintain supporting documentation as specified by TENNCARE that shall be made available to TENNCARE upon request.
- 2.9.8.4.11 The CONTRACTOR shall track the member's residency throughout the 365-day MFP participation period. In addition, the CONTRACTOR shall, for purposes of facilitating completion of Quality of Life surveys, continue to track MFP participants' residency for two (2) years following transition to the community which may be up to one (1) year following completion of the MFP participation period, or until the member is no longer enrolled in the CONTRACTOR's health plan.
- 2.9.8.4.12 The CONTRACTOR shall, using a template provided by TENNCARE, issue a written notice of MFP participation to each member enrolled in MFP which shall not occur prior to transition from CHOICES Group 1 to CHOICES Group 2. Such notice shall be issued within ten (10) business days of notification from TENNCARE via the outbound 834 enrollment file furnished by TENNCARE to the CONTRACTOR that the member is enrolled in MFP.
- 2.9.8.4.13 The CONTRACTOR shall, using a template provided by TENNCARE, issue a written notice to each member upon conclusion of the 365-day participation period. Such notice shall be issued within ten (10) business days of notification from TENNCARE via the outbound 834



enrollment file furnished by TENNCARE to the CONTRACTOR that the member is no longer enrolled in MFP.

- 2.9.8.4.14 A member who successfully completes 365-day participation period for MFP and is subsequently re-institutionalized may qualify to participate in MFP again but must first meet the “Eligible Individual” criteria. There shall be a minimum of ninety (90) days between MFP participation occurrences. Prior to enrollment in a second MFP occurrence, the care coordinator shall assess the reason for the re-institutionalization to determine if the member is an appropriate candidate for re-enrollment in MFP and if so, shall develop a plan of care (including a Risk Agreement) that will help to ensure that appropriate supports and services are in place to support successful transition and permanency in the community.

2.9.8.5 Plan of Care

- 2.9.8.5.1 For members participating in the MFP, the Plan of Care shall reflect that the member is an MFP participant, including the date of enrollment into MFP (i.e., date of transition from CHOICES Group 1 to CHOICES Group 2).
- 2.9.8.5.2 Upon conclusion of the member’s 365-day participation period in MFP, the Plan of Care shall be updated to reflect that he is longer participating in MFP.

2.9.8.6 Services

- 2.9.8.6.1 A member enrolled in MFP shall be simultaneously enrolled in CHOICES Group 2 and shall be eligible to receive covered benefits as described in 2.6.1.

2.9.8.7 Continuity of Care

- 2.9.8.7.1 Upon completion of a person’s 365-day participation in MFP, services (including CHOICES HCBS) shall continue to be provided in accordance with the covered benefits described in 2.6.1 and the member’s plan of care. Transition from participation in MFP and CHOICES Group 2 to participation *only* in CHOICES Group 2 shall be seamless to the member, except that the CONTRACTOR shall be required to issue notice of the member’s conclusion of his 365-day MFP participation period.

2.9.8.8 Level of Care and Short-Term Nursing Facility Stay in MFP

- 2.9.8.8.1 In order to enroll in MFP, a member must meet NF LOC. Group 3 members are not eligible for MFP.
- 2.9.8.8.2 A CHOICES Group 2 member participating in MFP who meets the nursing facility level of care in place at the time of admission may be admitted for an inpatient short-term nursing facility stay during his 365-day participation period and remain enrolled in MFP regardless of the number of days the member is admitted for inpatient facility care.
- 2.9.8.8.3 MFP participants admitted for short-term nursing facility stays shall be re-instated in MFP upon discharge and return to a Qualified Residence in the community. The member is not required to meet the ninety (90) day residency requirement criteria for re-instatement into MFP.



Amendment 32 (cont.)

- 2.9.8.8.4 If the short-term stay will exceed ninety (90) days, the CONTRACTOR shall facilitate transition from CHOICES Group 2 to CHOICES Group 1.
- 2.9.8.8.5 The member's care coordinator shall monitor the member's inpatient stay and shall visit the member face-to-face at least monthly during the inpatient stay or more frequently as necessary to facilitate timely and appropriate discharge planning.
- 2.9.8.8.6 The CONTRACTOR shall conduct a Transition Assessment and develop a Transition Plan (see Section 2.9.6.8) as necessary to facilitate the member's return to the community. Such assessment shall include a review of the circumstances which resulted in the nursing facility admission and shall evaluate whether the services and supports provided to the member are sufficient to safely meet his needs in the community such that transition back to CHOICES Group 2 and continued participation in MFP is appropriate. The CONTRACTOR shall update the member's plan of care, including the member's Risk Agreement, as deemed necessary based on the member's needs and circumstances.
- 2.9.8.8.7 Upon discharge from the short-term stay, within one (1) business day, the care coordinator shall visit the member in his/her Qualified Residence. During the ninety (90) days following transition and re-instatement into MFP, the care coordinator shall conduct monthly face-to-face in-home visits to ensure that the plan of care is being followed, that the plan of care continues to meet the member's needs, and the member has successfully transitioned back to the community.
- 2.9.8.8.8 MFP participants admitted for short-term nursing facility stays shall be re-instated in MFP upon discharge and return to a Qualified Residence in the community. The member is not required to meet the ninety (90) day residency requirement criteria for re-instatement into MFP.
- 2.9.8.8.9 Days that are spent in an inpatient facility, including short-term nursing facility stays, do not count as part of the member's 365-day MFP participation period.
- 2.9.8.9 TPAES
- 2.9.8.9.1 The CONTRACTOR shall use the TENNCARE PreAdmission Evaluation System (TPAES) to facilitate enrollments into and transitions between LTC programs, including CHOICES and the State's MFP Rebalancing Demonstration (MFP), and shall comply with all data collection processes and timelines established by TENNCARE in policy or protocol in order to gather data required to comply with tracking and reporting requirements pertaining to MFP. This shall include (but is not limited to) attestations pertaining to Eligible Individual and Qualified Residence, changes of residence, inpatient facility admissions and discharges, reasons for re-institutionalization, and reasons for disenrollment from MFP.
- 2.9.8.10 IT requirements
- 2.9.8.10.1 Pursuant to Section 2.23 of this Agreement, the CONTRACTOR shall modify its information systems to accommodate, accept, load, utilize and facilitate accurate and timely reporting on information submitted to by TENNCARE via the outbound 834 file that will identify MFP participants, as well as those MFP participants in suspended status during an inpatient admission.



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2.9.8.11 Case Management System

2.9.8.11.1 The CONTRACTOR’s case management system (see Section 2.9.6.12.7) shall identify persons enrolled in MFP and shall generate reports and management tools as needed to facilitate and monitor compliance with contract requirements and timelines.

2.9.8.12 MFP Readiness Review

2.9.8.12.1 Prior to implementation of MFP, as determined by TENNCARE, the CONTRACTOR shall demonstrate to TENNCARE’s satisfaction that the CONTRACTOR is able to meet all of the requirements pertaining to MFP set forth in this Agreement.

2.9.8.12.2 The CONTRACTOR shall cooperate in a “readiness review” conducted by TENNCARE to review the CONTRACTOR’s readiness to fulfill its obligations regarding MFP in accordance with the Agreement. This review may include, but is not limited to, desk and on-site review of documents provided by the CONTRACTOR, a walk-through of the CONTRACTOR’s operations, system demonstrations (including systems connectivity testing), and interviews with CONTRACTOR’s staff. The scope of the review may include any and all MFP requirements of the Agreement as determined by TENNCARE.

2.9.8.12.3 Based on the results of the review activities, TENNCARE will issue a letter of findings and, if needed, will request a corrective action plan from the CONTRACTOR.

2.9.8.13 MFP Benchmarks

2.9.8.13.1 The CONTRACTOR shall assist TENNCARE in meeting the five (5) annual benchmarks established for the MFP Rebalancing Demonstration which are described below in Sections 2.9.8.13.1.1 through 2.9.8.13.1.5.

2.9.8.13.1.1 *Benchmark # 1: Number of Persons Transitioned*

2.9.8.13.1.1.1 Assist the projected number of eligible individuals in each target group in successfully transitioning from an inpatient facility to a qualified residence during each year of the demonstration. Projected numbers:

Calendar Year	# of Elderly Transitioned	# of Disabled Adults Transitioned
2011	27	23
2012	206	169
2013	234	193
2014	261	214
2015	234	191
2016	206	169

2.9.8.13.1.1.2 Immediately prior to implementation of MFP and at the beginning of each calendar year thereafter, statewide calendar year numbers for benchmark #1 will be allocated on a regional basis to each MCO operating in the region, based on the number of persons in CHOICES Group 1. For purposes of incentive payments (see Section 3.11), achievement of this benchmark shall be determined on a regional basis by MCO.



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2.9.8.13.1.2 *Benchmark #2: Qualified Expenditures for HCBS*

2.9.8.13.1.2.1 Increase the amount and percentage of Medicaid spending for qualified home and community based long-term care services during each year of the demonstration.

2.9.8.13.1.2.2 For purposes of incentive payments (see Section 3.11), achievement of this benchmark shall be determined on a statewide basis.

2.9.8.13.1.3 *Benchmark #3: Increased Amount and Percentage of HCBS Participants*

2.9.8.13.1.3.1 Increase the number and percentage of individuals who are elderly and adults with physical disabilities receiving Medicaid-reimbursed long-term care services in home and community based (versus institutional) settings during each year of the demonstration.

2.9.8.13.1.3.2 For purposes of incentive payments (see Section 3.11), achievement of this benchmark shall be determined on a regional basis by MCO.

2.9.8.13.1.4 *Benchmark #4: Increase Unduplicated Contracted Community Based Residential Alternative*

2.9.8.13.1.4.1 Increase the number of unduplicated licensed CBRA's contracted with MCOs Statewide to provide HCBS in the CHOICES program during each year of the demonstration. Providers enrolled with more than one (MCO) or in more than one region shall only be counted once. Proposed numbers:

Calendar Year	# of MCO Contracted CBRA's Statewide
2011	70
2012	74
2013	78
2014	82
2015	86
2016	90

2.9.8.13.1.4.2 For purposes of incentive payments (See Section 3.11), achievement of this benchmark shall be determined on a statewide basis.



2.9.8.13.1.5 *Benchmark #5: Increase Participation in Consumer Direction*

2.9.8.13.1.5.1 Increase the number of persons receiving Medicaid-reimbursed HCBS participating in consumer direction for some or all services during each year of the demonstration. Projected numbers:

Calendar Year	# in Consumer Direction
2011	600
2012	900
2013	1,150
2014	1,400
2015	1,550
2016	1,650

2.9.8.13.1.5.2 Immediately prior to implementation of MFP and at the beginning of each calendar year thereafter, statewide calendar year numbers for benchmark #5 will be allocated on a regional basis to each MCO operating in the region, based on the number of persons in CHOICES Group 2 and Group 3. For purposes of incentive payments (see Section 3.11), achievement of this benchmark shall be determined on a regional basis by MCO.

38. Section 2.9.11.1 shall be deleted and replaced as follows:

2.9.11.1 Except as provided in Section 2.6.1.3, the CONTRACTOR is not responsible for the provision of pharmacy benefits; TENNCARE contracts with a pharmacy benefits manager (PBM) to provide these services. However, the CONTRACTOR shall maintain an agreement with the PBM for the purpose of making payment to the PBM on behalf of TENNCARE for TennCare covered services. This requirement does not impose any further responsibilities on the CONTRACTOR regarding the provider’s and/or provider’s claims that are reimbursed through this payment structure. The CONTRACTOR shall not be at risk for payment made to the TennCare contracted PBM (see Section 3). The CONTRACTOR shall coordinate with the PBM as necessary to ensure that members receive appropriate pharmacy services without interruption. The CONTRACTOR shall monitor and manage its contract providers as it relates to prescribing patterns and its members as it relates to utilization of prescription drugs. The CONTRACTOR shall participate in regularly scheduled meetings with the PBM and TENNCARE to discuss operational and programmatic issues.

39. Section 2.9.15 through 2.9.15.3 shall be deleted and replaced as follows:

2.9.15 ICF/IID Services and Alternatives to ICF/IID Services

2.9.15.1 The CONTRACTOR is not responsible for services in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or for services provided through Home and Community Based Services (HCBS) waivers as an alternative to ICF/IID services (hereinafter referred to as “HCBS ID waiver”). However, to the extent that services available to a member through a HCBS ID waiver are also covered services pursuant to this Agreement, the CONTRACTOR shall be responsible for providing all medically necessary covered services. HCBS ID waiver services may supplement, but not supplant, medically necessary covered services. ICF/IID services and HCBS ID waiver services shall be provided



to qualified members as described in TennCare rules and regulations through contracts between TENNCARE and appropriate providers.

- 2.9.15.2 The CONTRACTOR is responsible for covered services for members residing in an ICF/IID or enrolled in a HCBS ID waiver. For members residing in an ICF/IID, the CONTRACTOR is responsible for providing covered services that are not included in the per diem reimbursement for institutional services (e.g., prosthetics, some items of durable medical equipment, non-emergency ambulance transportation, and non-emergency transportation). Except as provided below for NEMT, for members enrolled in a HCBS ID waiver, the CONTRACTOR shall provide all medically necessary covered services, including covered services that may also be provided through the HCBS ID waiver. The HCBS ID waiver is the payor of last resort. However, the CONTRACTOR is not responsible for providing non-emergency medical transportation (NEMT) to any service that is being provided to the member through the HCBS ID waiver.
- 2.9.15.3 The CONTRACTOR shall coordinate the provision of covered services with services provided by ICF/IID and HCBS ID waiver providers to minimize disruption and duplication of services.

40. Section 2.11.1.10 shall be deleted and replaced as follows:

- 2.11.1.10 The CONTRACTOR shall monitor provider compliance with access requirements specified in Attachment III, including but not limited to appointment and wait times and take corrective action for failure to comply. The CONTRACTOR shall maintain an emergency/contingency plan in the event that a large provider of services collapses or is otherwise unable to provide needed services and shall conduct surveys and office visits to monitor compliance with appointment waiting time standards and shall report findings and corrective actions to TENNCARE in accordance with Section 2.30.8.2.

41. Section 2.12.9.15 shall be amended by adding a new sentence to the end of the existing text as follows:

- 2.12.9.15 Include a statement that as a condition of participation in TennCare, enrollees and providers shall give TENNCARE or its authorized representative, the Office of the Comptroller of the Treasury, and any health oversight agency, such as OIG, TBI MFCU, DHHS Office of Inspector General (DHHS OIG), and DOJ, and any other authorized state or federal agency, access to their records. Said records shall be made available and furnished immediately upon request by the provider for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring as well as for administrative, civil and criminal investigations or prosecutions upon the request of an authorized representative of the CONTRACTOR, TENNCARE or authorized federal, state and Office of the Comptroller of the Treasury personnel, including, but not limited to, the OIG, the TBI MFCU, the DHHS OIG and the DOJ. Said records are to be provided by the provider at no cost to the requesting agency;



42. Section 2.12 shall be amended by adding a new Section 2.12.15 as follows and renumbering the remaining Sections accordingly, including any references thereto.

2.12.15 The CONTRACTOR shall maintain an agreement with the PBM for the purpose of making payment to the PBM on behalf of TENNCARE for TennCare covered services. The agreement shall be in accordance with an approved template provided by TENNCARE. The CONTRACTOR shall not be at risk for payment made to the TennCare contracted PBM (see Section 3).

43. Section 2.13 shall be amended by adding a new Section 2.13.10 as follows and renumbering the remaining Sections accordingly, including any references thereto.

2.13.10 Payment to TennCare PBM

2.13.10.1 The CONTRACTOR shall make payment to the PBM on behalf of TENNCARE for TennCare covered services. The CONTRACTOR shall not be at risk for payment made to the TennCare contracted PBM (see Section 3). The CONTRACTOR shall adhere to the following process for payments to the PBM:

2.13.10.1.1 The CONTRACTOR shall maintain a separate bank account for the funds transfer from TENNCARE for purposes of payment to the PBM.

2.13.10.1.2 The CONTRACTOR shall receive a weekly invoice from the PBM for services rendered by the PBM.

2.13.10.1.3 The CONTRACTOR shall invoice TENNCARE for the cost of the payments to be made to the PBM based on the weekly PBM invoice as well as any associated regulatory costs.

2.13.10.1.4 The CONTRACTOR shall make payment to the PBM in the full amount of the funds transfer from TENNCARE no later than the Friday following receipt of the funds from TENNCARE unless extended by TENNCARE due to unforeseen circumstances or bank holidays.

44. Section 2.15.1.1 shall be deleted and replaced as follows:

2.15.1.1 The CONTRACTOR shall have a written Quality Management/Quality Improvement (QM/QI) program that clearly defines its quality improvement structures and processes and assigns responsibility to appropriate individuals. Program documents must include all of the elements listed below and shall include a separate section on CHOICES care coordination. This QM/QI program shall use as a guideline the current NCQA Standards and Guidelines for the Accreditation of MCOs and shall include the CONTRACTOR's plan for improving patient safety. This means at a minimum that the QM/QI program shall:

45. Section 2.15.2.1 shall be amended by adding the words “, annual evaluation” in the last sentence as follows:

2.15.2.1 The CONTRACTOR shall have a QM/QI committee which shall include medical, behavioral health, and long-term care staff and contract providers (including medical, behavioral health, and long-term care providers). This committee shall analyze and evaluate the results of QM/QI activities, recommend policy decisions, ensure that providers are involved in the QM/QI program, institute needed action, and ensure that appropriate follow-up occurs. This committee shall also review and approve the QM/QI program description, annual evaluation



and associated work plan prior to submission to TENNCARE as required in Section 2.30.12.1, Reporting Requirements.

46. Section 2.17.1.1 shall be deleted and replaced as follows:

2.17.1.1 The CONTRACTOR shall submit to TENNCARE for review and prior written approval all materials that will be distributed to members (referred to as member materials). Should the CONTRACTOR decide to contract with either a subcontractor or its providers to create and/or distribute member materials, the materials shall not be distributed to members unless the materials have been submitted to TENNCARE by the CONTRACTOR for review and prior written approval. Member Materials include, but are not limited to member handbooks, provider directories, member newsletters, identification cards, fact sheets, notices, brochures, form letters, mass mailings, system generated letters and any other additional, but not required, materials and information provided to members designed to promote health and/or educate members.

47. Section 2.17.2 shall be amended by adding a new Section 2.17.2.3 and renumbering the remaining Section 2.17.2 as follows, including any reference thereto.

2.17.2.3 Articles and/or informational material included in written materials such as newsletters, brochures, etc. shall be limited to approximately 200 words for purposes of readability unless otherwise approved in writing by TENNCARE;

48. Section 2.17.4.7.18 shall be deleted and replaced as follows:

2.17.4.7.18 Shall include notice of the right to file a discrimination complaint as provided for by applicable federal and state civil rights laws, including but not limited to, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, and Titles II and III of the Americans with Disabilities Act of 1990, and a complaint form on which to do so. The notice shall be considered a Vital Document and shall be available at a minimum in the English and Spanish languages;

49. Section 2.17.5.3.5 shall be deleted and replaced as follows:

2.17.5.3.5 A notice of the right to file a discrimination complaint, as provided for by applicable federal and state civil rights laws, including, but not limited to Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, Title IX of the Education amendments of 1972, Section 504 of the Rehabilitation Act of 1973, and Titles II and III of the Americans with Disabilities Act of 1990 and a complaint form on which to do so. The notice shall be considered a Vital Document and shall be available at a minimum in the English and Spanish languages;

50. Section 2.18.1.3 shall be deleted and replaced as follows:

2.18.1.3 The member services information line shall handle calls from individuals with LEP and individuals with disabilities, including, but not limited to individuals with hearing and/or speech disabilities.



51. Sections 2.20.1.7 through 2.20.1.7.3 shall be deleted and replaced as follows:

- 2.20.1.7 The CONTRACTOR is prohibited from taking any actions to recoup or withhold improperly paid funds already paid or potentially due to a provider when the issues, services or claims upon which the recoupment or withhold are based meet one or more of the following criteria:
- 2.20.1.7.1 The improperly paid funds have already been recovered by the State of Tennessee, either by TENNCARE directly or as part of a resolution of a state or federal investigation and/or lawsuit, including but not limited to false claims act cases; or
- 2.20.1.7.2 The improperly paid funds have already been recovered by the States Recovery Audit Contractor (RAC) contractor; or
- 2.20.1.7.3 When the issues, services or claims that are the basis of the recoupment or withhold are currently being investigated by the State of Tennessee, are the subject of pending Federal or State litigation or investigation, or are being audited by the TennCare RAC.

52. Section 2.21.6.1.4 shall be deleted and replaced as follows:

- 2.21.6.1.4 Except for those payments described in Section 4.8, any and all payments made by TENNCARE, including administrative fee payments, as well as incentive payments (if applicable) to the CONTRACTOR shall be considered "Premium revenue" for the purpose of calculating the minimum net worth required by TCA 56-32-112.

53. Section 2.23.5.2 shall be amended by adding a new sentence to the end of the existing text as follows:

- 2.23.5.2 The CONTRACTOR shall systematically update its eligibility/enrollment databases within twenty-four (24) hours of receipt of said files. Any outbound 834 transactions which fail to update/load systematically must be manually updated within twenty-four (24) hours of receipt. The CONTRACTOR shall report to TENNCARE, in a form and format to be provided by TENNCARE, outbound 834 transactions that are not processed within these time frames and include information regarding when the transactions were completed. Any transactions that are not updated/loaded within twenty-four (24) hours of receipt from TENNCARE and/or persistent issues with high volumes of transitions that require manual upload may require the CONTRACTOR to initiate a Corrective Action Plan for resolution of the issues preventing compliance. If the CONTRACTOR has reason to believe they may not meet this requirement based on unusual circumstances, the CONTRACTOR must notify TENNCARE and TENNCARE may make an exception without requiring a Corrective Action Plan.



54. Section 2.24.4.1 shall be amended by adding the phrase “on at least an annual basis” after the phrase “and a plan for training” as follows:

2.24.4.1 The CONTRACTOR shall develop and implement an abuse and neglect plan that includes protocols for preventing, identifying, and reporting suspected abuse, neglect, and exploitation of CHOICES members who are adults (see TCA 71-6-101 *et seq.*) and suspected brutality, abuse, or neglect of CHOICES members who are children (see TCA 37-1-401 *et seq.* and TCA 37-1-601 *et seq.*); a plan for educating and training providers, subcontractors, care coordinators, and other CONTRACTOR staff regarding the protocols; and a plan for training on at least an annual basis members, representatives, and caregivers regarding identification and reporting of suspected abuse and/or neglect.

55. Section 2.27 shall be amended by adding new Sections 2.27.9 and 2.27.10 as follows:

2.27.9 Medicaid and CHIP – Verification of Income and Eligibility. The CONTRACTOR must provide safeguards that restrict the use or disclosure of information concerning applicants and beneficiaries to purposes directly connected with the administration of the plan:

2.27.9.1 Purposes directly related to the administration of Medicaid and CHIP include:

2.27.9.1.1 Establishing eligibility;

2.27.9.1.2 Determining the amount of medical assistance;

2.27.9.1.3 Providing services for beneficiaries; and

2.27.9.1.4 Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to Medicaid or CHIP administration.

2.27.9.2 The CONTRACTOR must have adequate safeguards to assure that:

2.27.9.2.1 Information is made available only to the extent necessary to assist in the valid administrative purposes of those receiving the information, and information received under 26 USC § 6103(I) is exchanged only with parties authorized to receive that information under that section of the Code; and

2.27.9.2.2 The information is adequately stored and processed so that it is protected against unauthorized disclosure for other purposes.

2.27.9.3 The CONTRACTOR must have criteria that govern the types of information about applicants and beneficiaries that are safeguarded. This information must include at least:

2.27.9.3.1 Names and addresses;

2.27.9.3.2 Medical services provided;

2.27.9.3.3 Social and economic conditions or circumstances;

2.27.9.3.4 CONTRACTOR evaluation of personal information;



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- 2.27.9.3.5 Medical data, including diagnosis and past history of disease or disability;
- 2.27.9.3.6 Any information received for verifying income eligibility and amount of medical assistance payments, including income information received from SSA or the Internal Revenue Service;
- 2.27.9.3.7 Any information received for verifying income eligibility and amount of medical assistance payments;
- 2.27.9.3.8 Income information received from SSA or the Internal Revenue Service must be safeguarded according to Medicaid and CHIP requirements;
- 2.27.9.3.9 Any information received in connection with the identification of legally liable third party resources; and
- 2.27.9.3.10 Social Security Numbers.
- 2.27.9.4 The CONTRACTOR must have criteria approved by the State specifying:
 - 2.27.9.4.1 The conditions for release and use of information about applicants and beneficiaries;
 - 2.27.9.4.2 Access to information concerning applicants or beneficiaries must be restricted to persons or CONTRACTOR representatives who are subject to standards of confidentiality that are comparable to those of the State;
 - 2.27.9.4.3 The CONTRACTOR shall not publish names of applicants or beneficiaries;
 - 2.27.9.4.4 The CONTRACTOR shall obtain permission from a family or individual, whenever possible, before responding to a request for information from an outside source, unless the information is to be used to verify income, eligibility and the amount of medical assistance payment to an authorized individual or entity;
 - 2.27.9.4.5 If, because of an emergency situation, time does not permit obtaining consent before release, the CONTRACTOR shall notify the State, the family or individual immediately after supplying the information;
 - 2.27.9.4.6 The CONTRACTOR's policies must apply to all requests for information from outside sources, including governmental bodies, the courts, or law enforcement officials;
 - 2.27.9.4.6.1 The CONTRACTOR shall notify the State of any requests for information on applicants or beneficiaries by other governmental bodies, the courts or law enforcement officials ten (10) days prior to releasing the requested information.
 - 2.27.9.4.7 If a court issues a subpoena for a case record or for any CONTRACTOR representative to testify concerning an applicant or beneficiary, the CONTRACTOR must notify the State at least ten (10) days prior to the required production date so the State may inform the court of the applicable statutory provisions, policies, and regulations restricting disclosure of information, effective until Jan. 1, 2014; and
 - 2.27.9.4.8 The CONTRACTOR shall not request or release information to other parties to verify income, eligibility and the amount of assistance under Medicaid or CHIP, prior to express approval from the State.



- 2.27.10 Social Security Administration (SSA) Required Provisions for Data Security. The CONTRACTOR shall comply with limitations on use, treatment, and safeguarding of data under the Privacy Act of 1974 (5 U.S.C. § 552a), as amended by the Computer Matching and Privacy Protection Act of 1988, related Office of Management and Budget guidelines, the Federal Information Security Management Act of 2002 (44 U.S.C. § 3541, *et seq.*), and related National Institute of Standards and Technology guidelines. In addition, the CONTRACTOR shall have in place administrative, physical, and technical safeguards for data.
- 2.27.10.1 The CONTRACTOR shall not duplicate in a separate file or disseminate, without prior written permission from TENNCARE, the data governed by the Agreement for any purpose other than that set forth in this Agreement for the administration of the TennCare program. Should the CONTRACTOR propose a redisclosure of said data, the CONTRACTOR must specify in writing to TENNCARE the data the CONTRACTOR proposes to redisclose, to whom, and the reasons that justify the redisclosure. TENNCARE will not give permission for such redisclosure unless the redisclosure is required by law or essential to the administration of the TennCare program.
- 2.27.10.2 The CONTRACTOR agrees to abide by all relevant federal laws, restrictions on access, use, and disclosure, and security requirements in this Agreement.
- 2.27.10.3 The CONTRACTOR shall provide a current list of the employees of such CONTRACTOR with access to SSA data and provide such lists to TENNCARE.
- 2.27.10.4 The CONTRACTOR shall restrict access to the data obtained from TENNCARE to only those authorized employees who need such data to perform their official duties in connection with purposes identified in this Agreement. The CONTRACTOR shall not further duplicate, disseminate, or disclose such data without obtaining TENNCARE's prior written approval.
- 2.27.10.5 The CONTRACTOR shall ensure that its employees:
- 2.27.10.5.1 Properly safeguard PHI/PII furnished by TENNCARE under this Agreement from loss, theft or inadvertent disclosure;
- 2.27.10.5.2 Understand that they are responsible for safeguarding this information at all times, regardless of whether or not the CONTRACTOR employee is at his or her regular duty station;
- 2.27.10.5.3 Ensure that laptops and other electronic devices/ media containing PHI/PII are encrypted and/or password protected;
- 2.27.10.5.4 Send emails containing PHI/PII only if encrypted or if to and from addresses that are secure; and
- 2.27.10.5.5 Limit disclosure of the information and details relating to a PHI/PII loss only to those with a need to know.
- 2.27.10.6 CONTRACTOR employees who access, use, or disclose TENNCARE or TennCare SSA supplied data in a manner or purpose not authorized by this Agreement may be subject to civil and criminal sanctions pursuant to applicable federal statutes.



- 2.27.10.7 Loss or Suspected Loss of Data – If an employee of the CONTRACTOR becomes aware of suspected or actual loss of PHI/PII, the appropriate designee of the CONTRACTOR must immediately contact TENNCARE upon becoming aware to report the actual or suspected loss. The CONTRACTOR will use the Loss Worksheet located at http://www.tn.gov/tenncare/forms/phi_piiworksheet.pdf to quickly gather and organize information about the incident. The CONTRACTOR must provide TENNCARE with timely updates as any additional information about the loss of PHI/PII becomes available.
- 2.27.10.7.1 If the CONTRACTOR experiences a loss or breach of said data, TENNCARE will determine whether or not notice to individuals whose data has been lost or breached shall be provided and the CONTRACTOR shall bear any costs associated with the notice or any mitigation.
- 2.27.10.8 TENNCARE may immediately and unilaterally suspend the data flow under this Agreement, or terminate this Agreement, if TENNCARE, in its sole discretion, determines that the CONTRACTOR has: (1) made an unauthorized use or disclosure of TennCare SSA-supplied data; or (2) violated or failed to follow the terms and conditions of this Agreement.
- 2.27.10.9 In order to meet certain requirements set forth in the State’s Computer Matching and Privacy Protection Act Agreement (CMPPA) with the SSA, the Parties acknowledge that this Section shall be included in all agreements executed by or on behalf of the State. The Parties further agree that FISMA and NIST do not apply in the context of data use and disclosure under this Agreement as the Parties shall neither use nor operate a federal information system on behalf of a federal executive agency. Further, NIST is applicable to federal information systems; therefore, although encouraged to do so, the State, its CONTRACTORS, agents and providers are not required to abide by the NIST guidelines.
- 2.27.10.10 This Section further carries out Section 1106(a) of the Act (42 U.S.C. § 1306), the regulations promulgated pursuant to that section (20 C.F.R. Part 401), the Privacy Act of 1974 (5 U.S.C. § 552a), as amended by the Computer Matching and Privacy Protection Act of 1988, related Office of Management and Budget (“OMB”) guidelines, the Federal Information Security Management Act of 2002 (“FISMA”) (44 U.S.C. § 3541, *et seq.*), and related National Institute of Standards and Technology (“NIST”) guidelines, which provide the requirements that the SSA stipulates that the CONTRACTOR must follow with regard to use, treatment, and safeguarding data in the event data is exchanged with a federal information system.
- 2.27.10.11 Definitions
- 2.27.10.11.1 “SSA-supplied data” – information, such as an individual’s social security number, supplied by the Social Security Administration to TENNCARE to determine entitlement or eligibility for federally-funded programs (CMPPA between SSA and F&A; IEA between SSA and TENNCARE).
- 2.27.10.11.2 “Protected Health Information/Personally Identifiable Information” (PHI/PII) (45 C.F.R. § 160.103; OMB Circular M-06-19) – Protected health information means individually identifiable health information that is: (i) Transmitted by electronic media; (ii) Maintained in electronic media; or (iii) Transmitted or maintained in any other form or medium.
- 2.27.10.11.3 “Individually Identifiable Health Information” – information that is a subset of health information, including demographic information collected from an individual, and: (1) Is created or received by a health care provider, health plan, employer, or health care



clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) identifies the individual; or (ii) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

2.27.10.11.4 “Personally Identifiable Information” – any information about an individual maintained by an agency, including, but not limited to, education, financial transactions, medical history, and criminal or employment history and information which can be used to distinguish or trace an individual's identity, such as their name, Social Security Number, date and place of birth, mother's maiden name, biometric records, including any other personal information which can be linked to an individual.

56. Section 2.29.1.3.9 shall be deleted and replaced as follows:

2.29.1.3.9 A staff person to serve as the CONTRACTOR's Non-discrimination Compliance Coordinator. This person shall be responsible for the CONTRACTOR's compliance with applicable federal and state civil rights laws, regulations, rules and policies, including but not limited to, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Titles II and III of the Americans with Disabilities Act of 1990, and the Age Discrimination Act of 1975. The CONTRACTOR shall report to TENNCARE in writing, to the attention of the Director of Non-discrimination Compliance, within ten (10) calendar days of the commencement of any period of time that the CONTRACTOR does not have a designated staff person for non-discrimination compliance. The CONTRACTOR shall report to TENNCARE at such time that the function is redirected as required in Section 2.29.1.2;

57. Section 2.30.3 shall be deleted and replaced as follows:

2.30.3 Community Outreach

2.30.3.1 The CONTRACTOR shall submit an *Annual Community Outreach Plan* no later than November 30 of each year for review and approval by TENNCARE. The Annual Community Outreach Plan shall be written in accordance with guidance prepared by TENNCARE. It shall include, but is not limited to: all proposed community/health education events related to TENNderCare; community/health education events unrelated to TENNderCare; and a process for evaluating the benefits of the events.

2.30.3.2 The CONTRACTOR shall submit an *Annual Community Outreach Evaluation*, in a format specified by TENNCARE, of its approved Annual Community Outreach Plan no later than ninety (90) days following the end of a calendar year.

58. Sections 2.30.6.5 and 2.30.6.6 shall be amended by deleting the references to “homemaker” and “homemaker services”.

59. Section 2.30.8.2 shall be deleted and replaced as follows:

2.30.8.2 The CONTRACTOR shall submit an annual *Provider Compliance with Access Requirements Report* that summarizes the CONTRACTOR's monitoring activities, findings, and opportunities for improvement regarding provider compliance with applicable access



standards as well as an emergency/contingency plans in the event that a large provider of services collapses or is otherwise unable to provide needed services. This report/plan shall also be available upon request. (See Section 2.11.1.10.)

60. Section 4.2 shall be deleted and replaced as follows:

4.2 PAY-FOR-PERFORMANCE QUALITY INCENTIVE PAYMENTS

4.2.1 General

- 4.2.1.1 TENNCARE will make incentive payments to the CONTRACTOR in accordance with this Section 4.2.
- 4.2.1.2 The TennCare Select HEDIS score for the previous calendar year for each of the measures specified in Sections 4.2.2 and 4.2.3.2 will serve as the baseline rate in the NCQA minimum effect size change calculations (see Section 4.2.5 below).
- 4.2.1.3 Beginning on July 1, 2015, the CONTRACTOR shall be eligible for incentives in accordance with Section 4.2.4 below and the incentives described in Sections 4.2.2 and 4.2.3 shall no longer apply.
- 4.2.1.4 If NCQA makes changes in any of the measures selected by TENNCARE, such that valid comparison to prior years will not be possible, TENNCARE, at its sole discretion, may elect to either eliminate the measure from pay-for-performance incentive eligibility or replace it with another measure.

4.2.2 Physical Health HEDIS Measures

- 4.2.2.1 Beginning on July 1, 2010, on July 1 of each year through July 1, 2014, the CONTRACTOR will be eligible for a \$.03 PMPM payment, applied to member months from the preceding calendar year, for each of the audited HEDIS measures specified in Section 4.2.2.2 below (calculated from the preceding calendar year's data) for which significant improvement has been demonstrated. Significant improvement is defined using NCQA's minimum effect size change methodology (see Section 4.2.5 below).
- 4.2.2.2 Incentive payments will be available for the following audited HEDIS measures:
 - 4.2.2.2.1 Appropriate Treatment for Children with Upper Respiratory Infection (URI);
 - 4.2.2.2.2 Childhood Immunization Status - MMR;
 - 4.2.2.2.3 Children and Adolescents' Access to PCP – 7-11 year old age group;
 - 4.2.2.2.4 Children and Adolescents' Access to PCP – 12-19 year old age group;
 - 4.2.2.2.5 Well Child Visits – 3rd, 4th, 5th and 6th years of life; and
 - 4.2.2.2.6 Adolescent Well Care Visits.



4.2.3 Behavioral Health HEDIS Measures

- 4.2.3.1 On July 1 of 2011, the CONTRACTOR will be eligible for a \$.03 PMPM payment, applied to member months from the preceding calendar year, for each of the following audited HEDIS measures (calculated from the preceding calendar year's data) for which the CONTRACTOR scores at or above the 75th national Medicaid percentile, as calculated by NCQA. To be eligible for incentive payment for a measure, the CONTRACTOR must score at or above the 75th percentile for both rates comprising the measure.
- 4.2.3.2 Follow-up After Hospitalization for Mental Illness; and
- 4.2.3.3 Follow-up Care for Children Prescribed ADHD Medication.
- 4.2.3.4 Beginning on July 1, 2012, on July 1 of each year through July 1, 2014, the CONTRACTOR will be eligible for a \$.03 PMPM payment, applied to member months from the preceding calendar year, for each of the audited HEDIS measures specified in Section 4.2.3 below (calculated from the preceding calendar year's data) for which significant improvement has been demonstrated. To be eligible for incentive payment for a measure, the CONTRACTOR must demonstrate significant improvement for both rates comprising the measure. Significant improvement is defined using NCQA's minimum effect size change methodology (see Section 4.2.5 below).
- 4.2.3.5 Follow-up After Hospitalization for Mental Illness; and
- 4.2.3.6 Follow-up Care for Children Prescribed ADHD Medication.

4.2.4 HEDIS Measures (Beginning July 1, 2015)

- 4.2.4.1 On July 1 of each year, the CONTRACTOR will be eligible for a \$.03 PMPM payment, applied to member months from the preceding calendar year, for each of the audited HEDIS measures in accordance with Section 4.2.4.2 below (calculated from the preceding calendar year's data) for which significant improvement has been demonstrated. Significant improvement is defined using NCQA's minimum effect size change methodology (see Section 4.2.5 below).
- 4.2.4.2 Incentive payments will be available for selected audited HEDIS measures as determined by TENNCARE following review and analysis of HEDIS plan-specific rates.
- 4.2.4.3 Beginning calendar year 2014, in August of each year TENNCARE will notify the CONTRACTOR of the audited HEDIS measures that have been selected for eligibility for the following calendar year's Pay-For-Performance Quality Incentive Measures in each region for which the CONTRACTOR serves.
- 4.2.4.4 The annual notification will advise the CONTRACTOR of the specifics that TENNCARE will use to determine eligibility for the Pay-For-Performance Quality Incentive Payments.



4.2.5 NCQA Minimum Effect Size Change Methodology

The NCQA minimum effect size change methodology is as follows:

Baseline Rate	Minimum Effect Size
0-59	At least a 6 percentage point change
60-74	At least a 5 percentage point change
75-84	At least a 4 percentage point change
85-92	At least a 3 percentage point change
93-96	At least a 2 percentage point change
97-99	At least a 1 percentage point change

61. Section 4.5 shall be amended by adding the phrase “for all payments received under this Contract” as follows:

4.5 HMO PAYMENT

The CONTRACTOR shall be responsible for payment of applicable taxes for all payments received under this Contract pursuant to TCA 56-32-124. Payments to the CONTRACTOR shall be increased sufficiently to cover any additional amount due pursuant to Tennessee Code Annotated Section 56-32-124 thirty days after the end of each calendar year quarter. In the event the amount due pursuant to TCA 56-32-124 is increased during the term of this Contract, the payments to the CONTRACTOR shall be increased by an amount equal to the increase in the amount due by the CONTRACTOR.

62. Section 4 shall be amended by adding a new Section 4.8 as follows and renumbering the remaining Section accordingly, including any references thereto.

4.8 PAYMENT FOR DISTRIBUTION TO TENNCARE’S PBM

4.8.1 TENNCARE shall make a payment to the CONTRACTOR in an amount equal to the invoice that is billed to the CONTRACTOR by the TennCare PBM. The CONTRACTOR shall make payment to the TennCare PBM no later than the Friday following receipt of the payment from TENNCARE unless extended by TENNCARE due to unforeseen circumstances or bank holidays.

63. Section 5.3.10 shall be deleted and replaced as follows:

5.3.10 42 U.S.C. § 18116. .

64. The Program Issue in Level A.17 of Section 5.20.2.2.7 shall be amended by deleting “homemaker.”.

65. The Program Issue in Level B.23 of Section 5.20.2.2.7 shall be amended by adding the following references: “2.9.6.2.3.4(4), 2.9.6.5.1.1, 2.9.6.9.2.1.2, 2.9.6.9.3, and 2.24.4.2.1.



Amendment 32 (cont.)

66. Attachment III shall be amended by deleting and replacing the last bullet point before the final 2 paragraphs as follows:

- All other services not specified here shall meet the usual and customary standards for the community as determined by TENNCARE.

67. Attachment V shall be amended by deleting and replacing the Geographic Access Requirement for Psychiatric Inpatient Hospital Services as follows:

Psychiatric Inpatient Hospital Services	Travel distance does not exceed 90 miles for at least 90% of members	4 hours (emergency involuntary)/24 hours (involuntary)/24 hours (voluntary)
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68. ~~Section A.5.5.1 of Attachment XI shall be deleted and replaced as follows:~~

~~A.5.5.1 The CONTRACTOR shall provide a trip manifest to the NEMT provider of all new trips requested no later than four (4) business days before the date of the NEMT service.~~

SCP
6/13/13

69. Section 2.12.9 shall be amended by adding a new Section 2.12.9.60 and renumbering the remaining Section accordingly, including any references thereto.

CD
6/13/2013

2.12.9.60 Specify in applicable provider agreements that all providers who participate in the federal 340B program give TennCare MCOs the benefit of 340B pricing;



Amendment 32 (cont.)

All of the provisions of the original Agreement not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective June 1, 2013.

The State is not bound by this Amendment until it is signed by the contract parties and approved by appropriate officials in accordance with applicable Tennessee laws and regulations (depending upon the specifics of this Contract, said officials may include, but are not limited to, the Commissioner of Finance and Administration, the Commissioner of Human Resources, and the Comptroller of the Treasury).

The CONTRACTOR, by signature of this Amendment, hereby affirms that this Amendment has not been altered and therefore represents the identical document that was sent to the CONTRACTOR by TENNCARE.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

VOLUNTEER STATE HEALTH PLAN, INC.

BY: Mark A. Emkes / CD 6/13/2013
Mark Emkes
Commissioner

BY: Scott C. Pierce *SCP 6/13/13*
Scott C. Pierce
President & CEO VSHP

DATE: 5/14/2013

DATE: 4/21/13



CONTRACT SUMMARY SHEET

RFS Number:	31866-00026	Edison #	29635	Contract Number:	FA-02-14632-31
State Agency:	Department of Finance and Administration			Division:	Bureau of TennCare
Contractor				Contract Identification Number	
VSHP (TennCare Select)				<input type="checkbox"/> V- <input type="checkbox"/> C-	Edison Vendor #0000071694

Service Description

Managed Care Organization / Medically Necessary Health Care Services to the TennCare/Medicaid Population

Contract Begin Date	Contract End Date
7/1/2001	12/31/2014

Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66	4A2	134	11	<input type="checkbox"/> STARS		
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)	
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$ 18,599,868.48	
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$ 33,079,942.80	
2004	\$ 25,125,990.72	\$ 38,364,165.90			\$ 63,490,156.62	
2005	\$ 58,007,447.00	\$ 58,007,447.00			\$ 116,014,894.00	
2006	\$ 87,748,111.00	\$ 87,748,111.00			\$ 175,496,222.00	
2007	\$ 87,748,111.00	\$ 87,748,111.00			\$ 175,496,222.00	
2008	\$ 72,610,000.00	\$ 127,390,000.00			\$ 200,000,000.00	
2009	\$ 72,610,000.00	\$ 127,390,000.00			\$ 200,000,000.00	
2010	\$ 100,882,479.00	\$ 304,024,121.00			\$ 404,906,600.00	
2011	\$ 131,085,619.00	\$ 312,820,981.00			\$ 443,906,600.00	
2012	\$ 149,893,942.00	\$ 294,012,658.00			\$ 443,906,600.00	
2013	\$ 150,102,578.00	\$ 293,804,022.00			\$ 443,906,600.00	
2014	\$ 153,147,777.00	\$ 290,758,823.00			\$ 443,906,600.00	
Total:	\$ 1,111,503,115.35	\$ 2,051,207,190.55			\$ 3,162,710,305.90	

CFDA#	93.778 Title XIX Dept. of Health & Human Svcs.	Check the box ONLY if the answer is YES:
State Fiscal Contract		Is the Contractor a SUBRECIPIENT? (per OMB A-133)
Name:	Casey Dungan	Is the Contractor a Vendor? (per OMB A-133)
Address:	310 Great Circle Road Nashville, TN	Is the Fiscal Year Funding STRICTLY LIMITED?
Phone:	(615)507-6482	Is the Contractor on STARS?
Procuring Agency Budget Officer Approval Signature		Is the Contractor's FORM W-9 ATTACHED?
Casey Dungan		Is the Contractor's Form W-9 Filed with Accounts?

COMPLETE FOR ALL AMENDMENTS (only)			Funding Certification
CONTRACT END DATE:	Base Contract & Prior Amendments	This Amendment ONLY	Funding Certification (certification, required by T.C.A., § 9-4-5113, that there is a balance in the appropriation from which the obligated expenditure is required to be paid that is not otherwise encumbered to pay obligations previously incurred)
	12/31/2014		
FY: 2002	\$ 18,599,868.48		
FY: 2003	\$ 33,079,942.80		
FY: 2004	\$ 63,490,156.62		
FY: 2005	\$ 116,014,894.00		
FY: 2006	\$ 175,496,222.00		
FY: 2007	\$ 175,496,222.00		
FY: 2008	\$ 200,000,000.00		
FY: 2009	\$ 200,000,000.00		
FY: 2010	\$ 404,906,600.00		
FY: 2011	\$ 443,906,600.00		
FY: 2012	\$ 443,906,600.00		
FY: 2013	\$ 443,906,600.00		
FY: 2014	\$ 443,906,600.00		
Total:	\$ 3,162,710,305.90		



AMENDMENT NUMBER 31

**AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.**

CONTRACT NUMBER: FA-02-14632-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as specified below.

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. Section 2.13.9 shall be deleted and replaced as follows:

2.13.9 Medicaid Payment for Primary Care

- 2.13.9.1 In accordance with the Patient Protection and Affordable Care Act of 2010 (The Affordable Care Act), for calendar years 2013 and 2014, the CONTRACTOR shall make payments for certain primary care services (as described by CMS) and furnished by primary care providers (as described by CMS) in an amount that has been determined by CMS. Payments and reporting as required by this Section 2.13.9 shall be effective for dates of service beginning January 1, 2013. Should retroactive payments be necessary due to the timing of the implementation of this requirement, the CONTRACTOR shall make adjustments to previously paid claims for the enhanced payment to eligible primary care providers without any effort from the provider.
- 2.13.9.2 In addition to the routine claims payment reports required by this Agreement, the CONTRACTOR shall report to TENNCARE any information related to this requirement in a format described by TENNCARE. At a minimum, the reports shall be sufficient to accomplish the following:
 - 2.13.9.2.1 Submit 2009 payment data on primary care services which qualify for payment under this rule;
 - 2.13.9.2.2 Assure payments made to specified primary care providers are at the minimum Medicare primary care payment levels as required by 42 CFR 447, subpart G. This includes the assurance that eligible providers receive direct and full benefit of the payment increase for each of the primary care services specified in the final rule implementing this section of The Affordable Care Act regardless of whether the provider is paid directly or through a capitated arrangement;



Amendment 31

2.13.9.2.3 Submit any documentation to TENNCARE, sufficient to enable TENNCARE and CMS to ensure that provider payments increase as required by 42 CFR 438.6(c)(5)(vi)(A) are made and to adequately document expenditures eligible for 100% FFP and to support all audit or reconciliation processes. TENNCARE shall report these data to CMS.



Amendment 31 (cont.)

All of the provisions of the original Agreement not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective March 15, 2013.

The State is not bound by this Amendment until it is signed by the contract parties and approved by appropriate officials in accordance with applicable Tennessee laws and regulations (depending upon the specifics of this contract, said officials may include, but are not limited to, the Commissioner of Finance and Administration, the Commissioner of Human Resources, and the Comptroller of the Treasury).

The CONTRACTOR, by signature of this Amendment, hereby affirms that this Amendment has not been altered and therefore represents the identical document that was sent to the CONTRACTOR by TENNCARE.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: Mark A. Emkes / CD
Mark Emkes
Commissioner

DATE: 2/14/2013

VOLUNTEER STATE HEALTH PLAN,
INC.

BY: Scott C. Pierce
Scott C. Pierce
President & CEO VSHP

DATE: 2-11-13



CONTRACT SUMMARY SHEET

RFS Number:	31866-00026	Edison #	29635	Contract Number:	FA-02-14632-30
State Agency:	Department of Finance and Administration			Division:	Bureau of TennCare
Contractor				Contract Identification Number	
VSHP (TennCare Select)				<input type="checkbox"/> V- <input type="checkbox"/> C-	Edison Vendor #0000071694

Service Description

Managed Care Organization / Medically Necessary Health Care Services to the TennCare/Medicaid Population

Contract Begin Date	Contract End Date
7/1/2001	12/31/2014

Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66	4A2	134	11	<input type="checkbox"/> STARS		
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)	
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$ 18,599,868.48	
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$ 33,079,942.80	
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2014	\$ 153,147,777.00	\$ 290,758,823.00			\$ 443,906,600.00	
Total:	\$ 1,111,503,115.35	\$ 2,051,207,190.55			\$ 3,162,710,305.90	

CFDA#	93.778 Title XIX Dept. of Health & Human Svcs.	Check the box ONLY if the answer is YES:	
State Fiscal Contract		Is the Contractor a SUBRECIPIENT? (per OMB A-133)	
Name:	Casey Dungan	Is the Contractor a Vendor? (per OMB A-133)	
Address:	310 Great Circle Road Nashville, TN	Is the Fiscal Year Funding STRICTLY LIMITED?	
Phone:	(615)507-6482	Is the Contractor on STARS?	
Procuring Agency Budget Officer Approval Signature		Is the Contractor's FORM W-9 ATTACHED?	
Casey Dungan		Is the Contractor's Form W-9 Filed with Accounts?	

COMPLETE FOR ALL AMENDMENTS (only)			Funding Certification
CONTRACT END DATE:	Base Contract & Prior Amendments	This Amendment ONLY	Funding Certification (certification, required by T.C.A., § 9-4-5113, that there is a balance in the appropriation from which the obligated expenditure is required to be paid that is not otherwise encumbered to pay obligations previously incurred)
	6/30/2013	12/31/2014	
FY: 2002	\$ 18,599,868.48		
FY: 2003	\$ 33,079,942.80		
FY: 2004	\$ 63,490,156.62		
FY: 2005	\$ 116,014,894.00		
FY: 2006	\$ 175,496,222.00		
FY: 2007	\$ 175,496,222.00		
FY: 2008	\$ 200,000,000.00		
FY: 2009	\$ 200,000,000.00		
FY: 2010	\$ 404,906,600.00		
FY: 2011	\$ 443,906,600.00		
FY: 2012	\$ 443,906,600.00		
FY: 2013	\$ 443,906,600.00		
FY: 2014		\$ 443,906,600.00	
Total:	\$ 2,718,803,705.90	\$ 443,906,600.00	



AMENDMENT NUMBER 30

**AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.**

CONTRACT NUMBER: FA-02-14632-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as specified below.

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. Section 1 shall be amended by adding the following new definitions:

Advance Determination- A decision made by the Bureau in accordance with the process and requirements described in Rule 1200-13-01-.05(6) that an Applicant would not qualify to enroll in CHOICES Group 3 (including Interim CHOICES Group 3) when enrollment into CHOICES Group 3 has not actually been denied or terminated, and which may impact the person's NF LOC eligibility.

Chronic Condition – as defined by Population Health (and AHRQ) is a condition that lasts 12 months or longer and meets one of both of the following tests: (a) it places limitation on self-care, independent living, and social interactions; (b) it results in the need for ongoing intervention with medical products, services, and special equipment (see Perrin et al., 1993)

Engaged – When a member consents to participate in a Population Health program, the member can be determined to be engaged.

Health Coaching – A method of guiding and motivating members participating in Population Health programs to address their health by engaging in self-care and, if needed, make behavioral changes to improve their health. Health coaching operates on the premise that increasing a member's confidence in managing their health and achieving their own goals will have a more lasting effect on outcomes.

Interactive Intervention (Touch) – As it pertains to Population Health it is a two way interaction in which the member receives self management support or health education by one of the following modes: an interactive mail-based communication (i.e. mail-based support or education requested by the member, communication in the form of a member survey, quiz or assessment of member knowledge gained from reading the communication); an interactive telephone contact; including an interactive voice response (IVR) module; an in person contact; and online contact including contact by an interactive web-based module; live chat and secure e-mail. Interactive contacts do not include completion of a health risk appraisal or contacts made only to make an appointment, leave a message, or acknowledge receipt of materials.



Amendment 30 (cont.)

Medical Home – As defined by Population Health and per NCQA, the Medical Home is a model for care provided by physician practices aimed at strengthening the physician-patient relationship by replacing episodic care based on illnesses and patient complaints with coordinated care and a long-term healing relationship.

Medical Home Lock-in Project – As referred to in CRA 2.8, the project combines the Patient Centered Medical Home with an incentive program based upon quality care. In this project members will only be allowed to see their assigned PCP or another participating PCP within their group /same TIN, because no other provider will be paid for providing services to them. The providers must agree with the health plan to meet specific annual quality of care metrics in their practice. Member outcomes and utilization patterns will be analyzed by the MCO to assess the effectiveness of the project. The primary care providers that meet all specifications and improve quality of care and member outcomes are rewarded by the health plan.

Medical Necessity - Medical Necessity and Medically Necessary as used in this Agreement shall have the meaning contained in Tenn. Code Ann. 71-5-144 and TennCare Rule 1200-13-16.

Non-Interactive Intervention (Touch) – As it pertains to Population Health it is a one way attempt to interact or communicate with members. There is no confirmation of receipt. This does not include completion of a health appraisal.

Plan of Care – As it pertains to Population Health it is a personalized plan to meet a member’s specific needs and contains the following elements: prioritized goals that consider member and care giver needs which are documented; a time frame for re-evaluation; the resources to be utilized; a plan for continuity of care, including transition of care and transfers; and uses a collaborative approach including family participation. The plan of care is built upon the information collected from the health assessment to actively engage the member in developing goals and identifying a course of action to respond to the members’ needs. The goals and actions in the plan of care must address medical, social, educational, and other services needed by the member. Providing educational materials alone does not meet the intent of this factor.

Population Health Care Coordination Program – The program addresses acute health needs or risks which need immediate attention. Assistance provided to enrollees is short-term and time limited in nature. Activities may include, but are not limited to, assistance with making appointments, transportation, social services, etc. and should not be confused with activities provided through the CHOICES Care Coordination Program.

2. Section 1 shall be amended by deleting and replacing the following definitions:

Area Agency on Aging and Disability (AAAD)– Agencies designated by the Commission on Aging and Disability or its successor organization to plan for and provide services to the elderly and disabled within a defined geographic area as provided by T.C.A. Title 71, Chapter 2.

CHOICES At-Risk Demonstration Group– Individuals who are age 65 and older and adults age 21 and older with physical disabilities who (1) meet nursing home financial eligibility for TennCare-reimbursed long term services and supports, (2) meet the nursing facility level of care in place on June 30, 2012, but not the nursing facility level of care criteria in place on July 1, 2012; and (3) in the absence of TENNCARE CHOICES HCBS available through CHOICES Group 3, are At Risk for Institutionalization as defined in TennCare Rules. The CHOICES At-Risk Demonstration Group is open only between July 1, 2012, through December 31, 2013. Individuals enrolled in the CHOICES At-Risk Demonstration Group



Amendment 30 (cont.)

as of December 31, 2013, may continue to qualify in this group after December 31, 2013, so long as they (1) continue to meet Nursing Facility financial eligibility and the LOC criteria in place when they enrolled; and (2) remain continuously enrolled in the CHOICES At-Risk Demonstration Group and in CHOICES 3.

CHOICES Group (Group) – One of the three groups of TennCare enrollees who are enrolled in CHOICES. There are three CHOICES groups:

Group 1

Medicaid enrollees of all ages who are receiving Medicaid-reimbursed care in a nursing facility.

Group 2

Persons age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who meet the nursing facility level of care, who qualify for TennCare either as SSI recipients or as members of the CHOICES 217-Like HCBS Group, and who need and are receiving CHOICES HCBS as an alternative to nursing facility care. The CHOICES 217-Like HCBS Group includes persons who could have been eligible under 42 CFR 435.217 had the state continued its 1915(c) HCBS waiver for elders and/or persons with physical disabilities. TENNCARE has the discretion to apply an enrollment target to this group, as described in TennCare rules and regulations.

Group 3

Persons age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who qualify for TennCare as SSI recipients, who do not meet the nursing facility level of care, but who, in the absence of CHOICES HCBS, are “at-risk” for nursing facility care, as defined by the State. TENNCARE has the discretion to apply an enrollment target to this group as described in TennCare rules and regulations.

Interim Group 3 (open for new enrollment only between July 1, 2012, through December 31, 2013)

Persons age 65 and older and adults age 21 and older with physical disabilities who qualify for TennCare as SSI eligibles or as members of CHOICES At-Risk Demonstration Group and who meet the NF LOC criteria in place as of June 30, 2012. There is no enrollment target on Interim Group 3.

All requirements set forth in this agreement regarding Group 3 members are applicable to Interim Group 3 members, except as explicitly stated otherwise. Interim Group 3 members are not subject to an enrollment target.

Risk Agreement – An agreement signed by a CHOICES Group 2 or 3 member who will receive CHOICES HCBS (or his/her representative) that includes, at a minimum, identified risks to the member of residing in the community and receiving HCBS, the possible consequences of such risks, strategies to mitigate the identified risks, and the member’s decision regarding his/her acceptance of risk. For members electing to participate in consumer direction, the risk agreement must include any additional risks associated with the member’s decision to act as the employer of record, or to have a representative act as the employer of record on his/her behalf. See Section 2.9.6 of this Agreement for related requirements.



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Subcontract – An agreement entered into by the CONTRACTOR with any other organization or person who agrees to perform any administrative function or service for the CONTRACTOR specifically related to securing or fulfilling the CONTRACTOR’s obligations to TENNCARE under the terms of this Agreement (e.g., claims processing, Population Health) when the intent of such an agreement is to delegate the responsibility for any major service or group of services required by this Agreement. This shall also include any and all agreements between any and all subcontractors for the purposes related to securing or fulfilling the CONTRACTOR’s obligations to TENNCARE under the terms of this Agreement. Agreements to provide covered services as described in Section 2.6 of this Agreement shall be considered provider agreements and governed by Section 2.12 of this Agreement.

Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) – The state agency having the authority to provide care for persons with mental illness, and /or substance abuse needs

Transition Allowance – A per member allotment not to exceed two thousand dollars (\$2,000) per lifetime which may, at the sole discretion of the CONTRACTOR, be provided as a cost-effective alternative to continued institutional care for a CHOICES Group 1 member in order to facilitate transition from a nursing facility to the community when such member will, upon transition to CHOICES Group 2 or Group 3, receive more cost-effective non-residential home and community based services or companion care. Items that may be purchased or reimbursed are only those items that the member has no other means to obtain and that are essential in order to establish a community residence when such residence is not already established and to facilitate the member’s safe and timely transition, including rent and/or utility deposits, essential kitchen appliances, basic furniture, and essential basic household items, such as towels, linens, and dishes.

3. Section 2.2 shall be amended by adding a new Section 2.2.3 as follows:

2.2.3 If the CONTRACTOR is part of a health maintenance organization holding company system as defined by TCA 56-11-101(b)(5), the CONTRACTOR agrees to comply with the Insurance Holding Company System Act of 1986 as set forth in TCA 56-11-101 et seq. The CONTRACTOR agrees to comply with the requirements of TCA 56-11-101 et seq. whether the CONTRACTOR is domiciled in Tennessee or is a foreign insurer or health maintenance organization subject to registration requirements and standards adopted by statute or regulation in the jurisdiction of its domicile that are substantially similar to this contained in TCA 56-11-101 et seq.

4. Section 2.4.6.1 shall be deleted and replaced as follows:

2.4.6.1 The CONTRACTOR shall receive, process, and update outbound 834 enrollment files from TENNCARE, The CONTRACTOR shall also receive, process, and update outbound 834 enrollment files from DCS for children in State custody who are to be given Immediate Eligibility for a forty-five (45) day period. Enrollment data shall be updated or uploaded systematically to the CONTRACTOR’s eligibility/enrollment database(s) within twenty-four (24) hours of receipt from TENNCARE/DCS. Any outbound 834 transactions which fail to update/load systematically must be manually updated within twenty-four (24) hours of receipt. The CONTRACTOR shall report to TENNCARE, in a form and format to be provided by TENNCARE, outbound 834 transactions that are not processed within these time frames and include information regarding when the transactions were completed. Any transactions that are not updated/loaded within twenty-four (24) hours of receipt from TENNCARE and/or persistent issues with high volumes of transitions that require manual upload may require the CONTRACTOR to initiate a Corrective Action Plan for resolution of the issues preventing compliance.



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5. Section 2.4.10 shall be deleted and replaced as follows:

2.4.10 Information Requirements Upon Enrollment

As described in Section 2.17 of this Agreement, the CONTRACTOR shall provide the following information to new members: a member handbook, an identification card, and information regarding how to access and/or request a general provider directory and/or a CHOICES provider directory. In addition, the CONTRACTOR shall provide CHOICES members with CHOICES member education materials (see Section 2.17.7).

6. Section 2.6.1.2.4 and 2.6.1.2.5 shall be deleted and replaced as follows:

2.6.1.2.4 Each of the CONTRACTOR's Population Health programs (see Section 2.8) shall address the needs of members who have co-morbid physical health and behavioral health conditions.

2.6.1.2.5 As required in Section 2.9.5.2.2, the CONTRACTOR shall provide the appropriate level of Population Health services (see Section 2.8.4 of this Agreement) to non-CHOICES members with co-morbid physical health and behavioral health conditions. These members should have a single case manager that is trained to provide Population Health services to enrollees with co-morbid physical and behavioral health conditions. If a member with co-morbid physical and behavioral conditions does not have a single case manager, the CONTRACTOR shall ensure, at a minimum, that the member's Population Health Care Manager collaborates on an ongoing basis with both the member and other individuals involved in the member's care. As required in Section 2.9.6.1.9 of this Agreement, the CONTRACTOR shall ensure that upon enrollment into CHOICES, the appropriate level of Population Health activities are integrated with CHOICES care coordination processes and functions, and that the member's assigned care coordinator has primary responsibility for coordination of all the member's physical health, behavioral health and long-term care needs. The member's care coordinator may use resources and staff from the CONTRACTOR's Population Health program, including persons with specialized expertise in areas such as behavioral health, to supplement but not supplant the role and responsibilities of the member's care coordinator/care coordination team. The CONTRACTOR shall report on its Population Health activities per requirements in Section 2.30.6.1.

7. Section 2.6.5.2.5 shall be deleted and replaced as follows:

2.6.5.2.5 For CHOICES Group 1 members transitioning from a nursing facility to Group 2 or Group 3, a one-time transition allowance, per member. The amount of the transition allowance shall not exceed two thousand dollars (\$2,000) and may be used for items such as, but not limited to, the first month's rent and/or utility deposits, kitchen appliances, furniture, and basic household items. When the CONTRACTOR elects to provide a Transition Allowance to a member transitioning to CHOICES Group 3, the amount of the Transition Allowance shall be applied to the member's Expenditure Cap.

8. Section 2.6.5.3 shall be amended by adding the phrase "or Group 3" in the last sentence as follows:

2.6.5.3 If the CONTRACTOR chooses to provide cost effective alternative services to a CHOICES member, in no case shall the cost of CHOICES HCBS, private duty nursing and home health care for Group 2 exceed a member's cost neutrality cap nor the total cost of CHOICES



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HCBS, excluding minor home modifications, for members in Group 3 exceed the expenditure cap. The total cost of CHOICES HCBS includes all covered CHOICES HCBS and other non-covered services that the CONTRACTOR elects to offer as a cost effective alternative to nursing facility care for CHOICES Group 2 members pursuant to Section 2.6.5.2 of this Agreement including, as applicable: CHOICES HCBS in excess of specified benefit limits, the one-time transition allowance for CHOICES Group 1 members who are transitioning to CHOICES Group 2 or Group 3, and NEMT for Groups 2 and 3

9. Section 2.6.6.2 shall be amended by deleting and replacing the words “disease management” with “Population Health” as follows:

2.6.6.2 The CONTRACTOR shall not offer or provide any services other than services covered by this Agreement (see Section 2.6.1) or services provided as a cost effective alternative (see Section 2.6.5) of this Agreement. However, the CONTRACTOR may provide incentives that have been specifically prior approved in writing by TENNCARE. For example, TENNCARE may approve the use of incentives given to enrollees to encourage participation in Population Health programs.

10. Section 2.7.6.4.7.2 shall be deleted and replaced as follows:

2.7.6.4.7.2 The CONTRACTOR shall provide for any follow up service within the scope of the federal Medicaid statute, including diagnostic or treatment services determined to be medically necessary when elevated blood lead levels are identified in children. Such services would include Population Health Care Coordination or Complex Case management services and a one (1) time investigation to determine the source of lead.

11. Section 2.8 shall be deleted and replaced in its entirety as follows:

2.8 POPULATION HEALTH

2.8.1 General

2.8.1.1 The CONTRACTOR shall establish and operate an integrated Population Health Program based upon risk stratification of the CONTRACTOR population. The Population Health Model touches members across the entire care continuum, promoting healthy behaviors and disease self management as well as providing care coordination and intense care management as needed and supported by evidence-based medicine and national best practices. The CONTRACTOR shall evaluate the entire enrollee population and identify enrollees for specific programs according to risk rather than disease specific categories. This approach shall include the following risk Levels and programs:

2.8.1.1.1 **Risk Level 0: Wellness Program**

2.8.1.1.2 **Risk Level 1: Low Risk Maternity, Health Risk Management and Care Coordination programs; and**

2.8.1.1.3 **Risk Level 2: Chronic Care Management, High Risk Pregnancy and Complex Case Management programs**



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2.8.2 Member Identification /Stratification Strategies

- 2.8.2.1 The CONTRACTOR shall utilize a combination of predictive modeling utilizing claims data, pharmacy data, and laboratory results, supplemented by referrals, UM data, and/ or health risk assessment results to stratify the member population into the following risk categories:
- 2.8.2.1.1 **Level 0-** The members eligible to participate at this Level shall be determined by predictive modeling to meet ALL of the following: lack of any identified health risks; lack of any identified chronic conditions [as identified by the Chronic Condition tool created by the Agency for Healthcare Research and Quality's (AHRQ)] HCUP database; no indication of pregnancy; and lack of claims history.
- 2.8.2.1.2 **Level 1-** All members that do not meet the Level 0 or Level 2 criteria.
- 2.8.2.1.2.1 All members identified as Level 1, through predicative modeling, and not pregnant are eligible for the **Health Risk Management Program**. At a minimum, the CONTRACTOR shall enroll members with the following chronic diseases: Asthma, Bipolar, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, Congestive Heart Disease, Diabetes, Major Depression, and Schizophrenia. The CONTRACTOR shall also provide this program for members they identify with other chronic diseases that are prevalent in a significant number of members, or for members with other chronic diseases utilizing significant health resources in their regional population.
- 2.8.2.1.2.1.1 The CONTRACTOR shall sub-stratify members identified for the Health Risk Management program into high, medium and low categories based on criteria developed by the CONTRACTOR and reported in the annual program description. The CONTRACTOR shall provide the minimum interventions for each category as outlined in Section 2.8.4.3 of this Agreement.
- 2.8.2.1.2.2 The CONTRACTOR shall identify members for the Level 1, **Care Coordination Program** through referrals, hospital and ED face sheets, and any other means of identifying members with acute health needs or risks which need immediate attention. Members are identified for Care Coordination because their needs do not meet the requirements for complex case management. Members, who have declined participation in Complex Case Management, may also be enrolled in Care Coordination.
- 2.8.2.1.3 **Level 2** – Members eligible to participate at this Level shall be determined by predictive modeling identifying the top three percent (3%) of members to be most at risk for adverse health outcomes, and/or by referrals or health risk assessments.
- 2.8.2.1.3.1 The CONTRACTOR shall identify members for the **Chronic Care Management Program** from those Level 2 members that are not pregnant but have complex chronic conditions with multiple identified health risks and or needs. This may include those members with co-occurring mental illness and substance abuse and/or co-morbid physical and behavioral health conditions. Members may also be identified for Chronic Care Management by referrals and health risk assessments.
- 2.8.2.1.3.2 The CONTRACTOR shall identify members for **Complex Case Management** from those Level 2 members that are not pregnant and have high risk, unique or complex needs. These may include members with co-occurring mental illness and substance abuse and/or co-morbid physical and behavioral health conditions. Members identified by



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utilization reports as high pharmacy user or those members which exceed the ED threshold, as defined by TENNCARE shall be reviewed for need for case management. Members may also be identified for Complex Case Management by referrals and health risk assessments.

- 2.8.2.1.4 The CONTRACTOR shall systematically stratify newly enrolled members on a monthly basis.
- 2.8.2.1.5 The CONTRACTOR shall systematically re-stratify the entire CONTRACTOR's population to identify the top 3% as defined in section 2.8.2.1.3 of this agreement at a minimum of quarterly intervals to insure members with increasing health risks and needs are identified for level 2 programs.
- 2.8.2.1.6 The CONTRACTOR shall systematically re-stratify the entire CONTRACTOR's population at a minimum annually.
- 2.8.2.2 The CONTRACTOR shall identify **pregnant members** through claims, referrals, and the 834 nightly feed, as well as through any other method identified by health plan.
- 2.8.2.2.1 The CONTRACTOR will stratify pregnant members into either **low or high risk maternity programs** based on the CONTRACTOR's obstetrical assessment. Pregnant members identified as substance abusers, including tobacco users, or who meet other high risk indicators shall be stratified as high risk. Pregnant members who, through the OB assessment, do not meet high risk needs and members who are identified for high risk maternity but choose not to participate, shall be enrolled in the low risk maternity program.

2.8.3 Member Assessment/Identification

- 2.8.3.1 At time of enrollment the CONTRACTOR shall make a reasonable attempt to assess the member's health.
- 2.8.3.2 For the Level 2 Population Health programs with a required Health Risk Assessment (HRA), such HRA shall include screening for mental health and substance abuse, physical health conditions, behavioral health conditions, recommended preventive health status and co-morbid physical and behavioral health conditions.
- 2.8.3.3 For members considered high risk, the assessment shall include documenting the individual health history, determining each member's health literacy status, identifying substance abuse and behavioral issues/problems, identifying needs and gathering information, when appropriate, from other sources (e.g., family members, medical providers, and educators).
- 2.8.3.4 For the voluntary programs of Chronic Care Management, Complex Case Management, or High Risk Maternity Programs, for members considered to have high health risks, shall include assessing the need for a face to face visit. If needed, such a visit shall be conducted following consent of the member.



2.8.4 Program Content and Minimum Interventions

The CONTRACTOR shall establish and implement program content and interventions, based on program objectives, member assessments and risk stratification, for the seven (7) Population Health Programs listed in Section 2.8.1 of this Agreement. Activities, interventions, and education objectives appropriate for members will vary for each program with increasing engagement and intensity as level of risk increases. Each program will have a minimum standard set of interventions and frequency of touches but utilize varying modes of communication to attain the program objective.

2.8.4.1 Wellness program

For all eligible **Level 0** members not pregnant the CONTRACTOR shall provide a **Wellness Program** with the objective of keeping members healthy as long as possible.

2.8.4.1.1 The Wellness Program shall utilize educational materials and or activities that emphasize primary and secondary prevention.

2.8.4.1.2 The CONTRACTOR shall provide to members eligible for the **WELLNESS PROGRAM** the following minimum interventions:

Wellness Program Minimum Interventions	
1.	One non-interactive educational quarterly touch to address the following within one year:
	<ul style="list-style-type: none"> A. How to be proactive in their health B. How to access a primary care provider C. Preconception and interconception health, to include Dangers of becoming pregnant while using narcotics D. Age and/or gender appropriate wellness preventive health services (e.g., “knowing your numbers”) E. Assessment of special population needs for gaps in care (e.g., recommended immunizations for <i>children and adolescents</i>) F. Health promotion strategies (e.g., discouraging tobacco use and/or exposure, weight management, stress management, physical activity, substance abuse prevention) G. Healthy nutrition H. Other healthy and safe life styles

2.8.4.2 Level 1: Low Risk Maternity Program

The CONTRACTOR shall provide a Level 1 Low Risk Maternity Program for eligible members identified as described in Sections 2.8.2.4 and 2.8.2.5 of this Agreement. The goal of the program is to engage pregnant women into timely prenatal care and to deliver a healthy, term infant without complications.

2.8.4.2.1 The CONTRACTOR shall operate its Level 1 Maternity Program using an “Opt Out” methodology. Maternity program services shall be provided to all eligible members unless they specifically ask to be excluded.



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2.8.4.2.2 The CONTRACTOR shall provide defined ongoing member monitoring for the need to move these members into the Level 2 High Risk Maternity Program.

2.8.4.2.3 The CONTRACTOR shall provide to members eligible for the **LEVEL 1 MATERNITY PROGRAM** the following minimum standard interventions:

Maternity Program Minimum Interventions	
1.	Screening for risk factors to include screening for mental health and substance abuse. This screening shall follow the contact attempt protocol referenced in Section 2.8.4.5.2 of this Agreement.
2.	Prenatal packets (considered the one non-interactive intervention to the member for the duration of the pregnancy) to include at a minimum: <ul style="list-style-type: none">A. Encouragement to access Text4BabyB. Access number to maternity nurse/social worker if member would like to engage in monthly maternity managementC. Preterm labor educationD. Breast feedingE. Secondhand smokeF. Safe sleepG. Specific trimester health informationH. Importance of postpartum visitI. Importance of screening for postpartum depressionJ. HUGS informationK. Inter-conception health, to include dangers of becoming pregnant while using narcotics
3.	Follow up as appropriate to determine the status of a prenatal visit to those members who received an initial assessment but had not scheduled or completed their first prenatal visit.
4.	Follow-up to all eligible members, to assess the status of a post-partum visit appointment and assist them with making their appointment if needed.

2.8.4.3 Health Risk Management Program

For eligible Level 1 members, who are not pregnant, identified as designated in Section 2.8.2.1.2.1 of this Agreement, the CONTRACTOR shall provide a **Health Risk Management** Program designed to empower members to be proactive in their health and support the provider-patient relationship. The interventions provided in this program shall address the program's goal of preventing, reducing or delaying exacerbation and complications of a condition or health risk behavior.

2.8.4.3.1 Health coaching or other interventions for health risk management shall emphasize self management strategies addressing healthy behaviors (i.e. weight management and tobacco cessation), self-monitoring, co-morbidities, cultural beliefs, depression screening, and appropriate communication with providers.

2.8.4.3.2 The CONTRACTOR shall develop and operate the "opt out" health risk management program per NCQA standard QI 8 for disease management. Program services shall be provided to eligible members unless they specifically ask to be excluded.



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- 2.8.4.3.3 The CONTRACTOR, through a welcome letter, shall inform members how to access and use services, and how to opt in or out of the program. The welcome letter may be used as the required non-interactive intervention if it includes all the required elements as detailed in Section 2.8.4.3.7 of this Agreement.
- 2.8.4.3.4 The CONTRACTOR shall provide, to members identified with weight management problems, education and support to address and improve this health risk. At the CONTRACTOR's discretion the CONTRACTOR may also provide, as cost effective alternatives, weight management programs for Level 1 or 2 members identified as overweight or obese.
- 2.8.4.3.5 The CONTRACTOR shall provide, to members identified as users of tobacco, information on availability of tobacco cessation benefits, support and referrals to available resources such as the Tennessee Tobacco Quitline.
- 2.8.4.3.6 The CONTRACTOR shall sub-stratify populations within the Health Risk Management Program (low, medium, high) based upon identified risk, life style choices (tobacco or substance use), referrals, and identified needs. Interventions for each subpopulation shall be based on risk level or the identified modifiable health risk behavior.
- 2.8.4.3.7 The CONTRACTOR shall provide to members, who are not participating in a Medical home Lock-in project, in the lowest risk level of the Health Risk Management Program the following minimum standard interventions:

Health Risk Management Program: <u>Lowest Risk Level</u> Minimum Interventions	
1.	<u>One</u> documented non-interactive communication each year. The communication shall address self management education emphasizing the following: <ul style="list-style-type: none"> A. Increasing the members knowledge of their chronic condition B. The importance of medication adherence C. Appropriate lifestyle/behavioral changes D. Management of the emotional aspect of their condition E. Self efficacy & support
2.	Offering of individual support for self management if member desires to become engaged.
3.	Availability of 24/7 nurse line.
4.	Availability of health coaching
5.	Availability of weight management or tobacco cessation support as applicable and as described in Sections 2.8.4.3.4 and 2.8.4.3.5 of this Agreement.

- 2.8.4.3.8 The CONTRACTOR shall provide to members, who are not participating in a Medical Home Lock-in project, in the medium risk level within the Health Risk Management Program the following minimum standard interventions:



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Health Risk Management Program: Medium Risk Level Minimum Interventions	
1.	<p><u>Two</u> documented non-interactive communications each year which shall emphasize self management education addressing the following:</p> <ul style="list-style-type: none"> A. Members knowledge of their chronic condition B. Importance of medication adherence C. Appropriate lifestyle/behavioral changes D. Management of emotional aspects of their condition E. Self efficacy & support
2.	Offering of interactive communications for self management if need is identified and member desires to become engaged.
3.	Availability of 24/7 nurse line.
4.	Health coaching to provide self management education and support if the need is identified or as requested by eligible members.
5.	Availability of weight management or tobacco cessation support as applicable and as described in Sections 2.8.4.3.4 and 2.8.4.3.5 of this Agreement.

2.8.4.3.9 The CONTRACTOR shall provide to members, who are not participating in a Medical Home Lock-in project, in the highest risk level within the Health Risk Management Program the following minimum interventions:

Health Risk Management Program: Highest Risk Level Minimum Interventions	
1.	<p><u>Four</u> documented non-interactive communications each year which shall emphasize the following:</p> <ul style="list-style-type: none"> A. Members knowledge of their chronic condition B. Importance of medication adherence C. Appropriate lifestyle/behavioral changes D. Management of emotional aspects of their condition E. Self efficacy & support
2.	<p>Offering of interactive communications for self management if need is identified and member desires to become engaged which may include;</p> <ul style="list-style-type: none"> A. Documented action plan as appropriate if the need is identified or are requested by eligible members B. Referrals and linkages to link the members with medical, social, educational and/or other providers or programs and services to address identified needs C. Monitoring and follow up which shall consist of activities and contacts that are necessary to ensure services, appointments and community resources were furnished as planned and shall be appropriately documented for reporting purposes



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	D. Defined monitoring for gaps in care
3.	Availability of 24/7 nurse line
4.	Health coaching to provide self management education and support if the need is identified or as requested by eligible members
5.	Availability of weight management or tobacco cessation support as applicable and as described in Sections 2.8.4.3.4 and 2.8.4.3.5

2.8.4.4 Care Coordination Program

For all eligible members the CONTRACTOR shall provide a Care Coordination Program designed to help non-CHOICES members who may or may not have a chronic disease but have acute health needs or risks that need immediate attention. The goal of the Care coordination program is to assure members get the services they need to prevent or reduce an adverse health outcome. Services provided are short-term and time limited in nature and should not be confused with the CHOICES Care Coordination Program. Services may include assistance in making and keeping needed medical and or behavioral health appointments, hospital discharge instructions, health coaching and referrals related to the members’ immediate needs, PCP reconnection and offering other resources or materials related to wellness, lifestyle, and prevention. Members receiving care coordination may be those members that were identified for, but declined complex case management

2.8.4.5. Chronic Care Management Program

For all eligible level 2 non-pregnant members the CONTRACTOR shall provide a **Chronic Care Management Program**. The goal of the program is to improve the quality of life, health status and utilization of services, of members with multiple chronic conditions, by providing intense self management education and support.

2.8.4.5.1 The CONTRACTOR shall develop and operate the “opt in” chronic care management program per NCQA standard QI 8 for disease management.

2.8.4.5.2 The CONTRACTOR shall make three outreach attempts to contact each newly identified member as eligible for Chronic Care Management to offer the member enrollment in the program. All eligible members must have three outreach attempts within three months of their identification. For those members where contact failed but appear on the next refreshed list the CONTRACTOR is not obligated to attempt another contact for one hundred and eighty (180) days.

2.8.4.5.3 Engagement rates for the Chronic Care Management program will be monitored by TENNCARE with baseline determined the first year with improvement from baseline expected in subsequent years. The NCQA Significant Improvement Chart will serve as the measurement of improvement in subsequent years.

2.8.4.5.4 The CONTRACTOR shall conduct a **comprehensive Health Risk Assessment (HRA)** for all members enrolled in the Chronic Care management Program. The HRA should include screening for mental health and substance abuse for all members and screening for physical conditions when member condition is behavioral.



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2.8.4.5.5 The CONTRACTOR shall provide to members, who are not participating in a Medical Home Lock-in project, enrolled in the **CHRONIC CARE MANAGEMENT PROGRAM** the following minimum standard interventions:

Chronic Care Management Program Minimum Interventions	
1.	Monthly interactive contacts addressing the following with one face-to-face visit as deemed appropriate by the CONTRACTOR: A. Development of a supportive member and health coach relationship B. Disease specific management skills such as medication adherence and monitoring of the member’s condition C. Negotiating with members for appropriate health and behavioral changes D. Problem solving techniques E. The emotional impact of member’s condition F. Self efficacy G. Referral and linkages to link the members with medical, social, educational and/or other providers or programs and services to address identified needs H. Regular and sustained monitoring and follow-up
2.	Clinical reminders related to gaps in care.
3.	Suggested elements of the member’s plan of care.
4.	Provision of after hour assistance with urgent or emergent needs.

2.8.4.5.6 The CONTRACTOR shall provide ongoing member assessment for the need to move these members into a lower risk classification or to the complex case management program for services.

2.8.4.6 High Risk Maternity

The CONTRACTOR shall provide a **Level 2 High Risk Maternity Program** for eligible members identified as described in Sections 2.8.2.3 and 2.8.2.3.1 of this Agreement. The goal of the program is to engage pregnant women into timely prenatal care and aim for delivery of a healthy, term infant without complications.

2.8.4.6.1 The CONTRACTOR shall provide screening for risk factors to include screening for mental health and substance abuse. This screening shall follow the attempt protocol referenced in Section 2.8.4.5.1 of this Agreement.

2.8.4.6.2 The CONTRACTOR shall operate its high risk maternity program using an “Opt In” methodology. Program services shall be provided to eligible members that agree to participate in the program.



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2.8.4.6.3 The CONTRACTOR shall provide to members enrolled in the **Level 2 HIGH RISK MATERNITY PROGRAM** the following minimum standard interventions:

High Risk Maternity Program Minimum Interventions	
1.	One interactive contact to the member per month of pregnancy to provide intense case management including the following:
	Development of member support relationship by face to face visit or other means as appropriate.
	Monthly interactive contacts to support and follow-up on patient self management. If prenatal visits have not been kept more frequent calls are required.
	Comprehensive HRA to include screening for mental health and substance abuse.
	Development and implementation of individualized care plan.
	Follow-up to assure member is established with a provider, receives prenatal and postpartum visits, and postpartum depression screening. If prenatal visits have not been kept more frequent calls are required.
	Referrals to appropriate community-based resources and follow-up for these referrals.
	If applicable, provide information on availability of tobacco cessation benefits, support and referrals to cessation services including TN tobacco Quitline.
2.	Provide prenatal packets including:
	Encouragement to enroll in Text4Baby.
	Encouragement (social marketing) to enroll in High Risk Maternity program.
	Information on preterm labor education.
	Information on breast feeding.
	Information on secondhand smoke.
	Information on safe sleep.
	Trimester specific health information.
	Information on importance of postpartum visit.
	Information on post partum Depression.
	Help Us Grow Successfully (HUGS) TDOH program information.
	Information on inter-conception health, including dangers of Becoming pregnant while using narcotics and long term Contraception.

2.8.4.7 Complex Case Management

The CONTRACTOR shall provide a **Complex Case Management Program (CCMP)** for eligible members, identified by criteria listed in Section 2.8.2 of this Agreement. The goal of the program is to move members to optimal levels of health and well-being by providing timely coordination of quality services and self management support.

2.8.4.7.1 The CONTRACTOR shall offer complex case management to all members identified as eligible. Members will have the right to participate or decline participation.

2.8.4.7.2 The CONTRACTOR shall make three (3) outreach attempts as detailed in Section 2.8.4.5.2 of this agreement.



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- 2.8.4.7.3 The CONTRACTOR shall develop and implement the Complex Case Management Program according to NCQA standard QI 7 for complex case management.
- 2.8.4.7.4 The CONTRACTOR shall conduct a comprehensive Health Risk Assessment to assess member’s needs to include screening for mental health and substance abuse for all members identified with a physical condition and screening for physical conditions when member’s condition is behavioral.
- 2.8.4.7.5 The CONTRACTOR shall provide defined ongoing member assessment for the need to move these members into a lower risk classification or into the Chronic Care Management Program.
- 2.8.4.7.6 The CONTRACTOR shall provide to members enrolled in the **COMPLEX CASE MANAGEMENT PROGRAM** the following:

Complex Case Management Program Minimum Interventions	
1.	Monthly interactive member contacts to provide individual self management support emphasizing the following:
	One face –to –face visit as deemed appropriate by MCO
	Development of a supportive member and health coach relationship
	Teaching disease specific management skills such as medication adherence and monitoring of the member’s condition
	Negotiating with members for appropriate health and behavioral changes
	Providing problem solving techniques
	Assist with the emotional impact of the member’s condition
	Self efficacy
	Providing regular and sustained monitoring and follow-up
	Referral and linkages
2.	Providing clinical reminders around HEDIS/gaps in care
3.	Providing after hours assistance with urgent or emergent member needs

2.8.5 Program Description

The CONTRACTOR shall develop and maintain a Population Health **Program Description** addressing all Sections of the CRA and following the guidance documents issued by the Bureau of TennCare, Quality Oversight Division. The program description shall include a written description of how the plan assures that members less than 21 years of age will have their health risks identified and their health needs met at the appropriate risk level.



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2.8.6 Clinical Practice Guidelines

Population Health programs shall utilize evidence-based clinical practice guidelines that have been formally adopted and updated as described in current NCQA standards. A list of clinical practice guidelines for conditions referenced in Section 2.8.2.1.2.1 of this Agreement, as well as Maternity, Obesity, and Preventive Services must be submitted for review by TENNCARE on an annual basis. For conditions other than those referenced in this citation policies and procedures established addressing how the health plan assures that information provided to member is based on current best practices.

2.8.7 Informing and educating Members

The CONTRACTOR shall inform all members of the availability of Population Health Programs and how to access and use the program services. The member shall be provided information regarding their eligibility to participate, how to self refer, and how to either appropriately “opt in” or “opt out” of a program.

2.8.8 Informing and Educating Practitioners

The CONTRACTOR shall educate providers regarding the operation and goals of all Population Health programs. The providers should be given instructions on how to access appropriate services as well as the benefits to the provider. For members receiving interactive interventions, the CONTRACTOR shall notify the practitioners by letter, email, fax, or via a secure web portal of their patient’s involvement.

2.8.9 System support and capabilities

The CONTRACTOR shall maintain and operate centralized information system necessary to conduct population health risk stratification. Systems recording program documentation shall meet NCQA Complex Case Management specifications and include the capability of collecting and reporting short term and intermediate outcomes such as member behavior change. The system shall be able to collect and query information on individual members as needed for follow-up confirmations and to determine intervention outcomes.

2.8.10 CHOICES

The CONTRACTOR shall include CHOICES members **and** dual eligible CHOICES members when risk stratifying its entire population.

2.8.10.2 The CONTRACTOR’s Population Health Program description shall describe how the organization integrates a CHOICES member’s information with other CONTRACTOR activities, including but not limited to, Utilization Management (UM), Health Risk assessment information, Health Risk Management and Chronic Care Management programs to assure programs are linked and enrollees receive appropriate and timely care.

2.8.10.3 The CONTRACTOR’s Population Health Program description shall address how the CONTRACTOR shall ensure that, upon enrollment into CHOICES, Health Risk Management or Chronic Care Management activities are integrated with CHOICES care coordination processes and functions, and that the member’s assigned care coordinator has primary responsibility for coordination of all the member’s physical health, behavioral health, and long-term care services, including appropriate management of chronic conditions. If a CHOICES member has one or more chronic conditions, the member’s care coordinator may



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use the CONTRACTOR's applicable Population Health Program's tools and resources, including staff with specialized training, to help manage the member's condition, and shall integrate the use of these tools and resources with care coordination. Population Health staff shall supplement, but not supplant, the role and responsibilities of the member's care coordinator/care coordination team.

- 2.8.10.4 The CONTRACTOR's program description shall also include the method for addressing the following for CHOICES members:
- 2.8.10.4.1 Notifying the CHOICES care coordinator of the member's participation in a Population Health Program;
 - 2.8.10.4.2 Providing member information collected to the CHOICES care coordinator.
 - 2.8.10.4.3 Provide to the CHOICES Care Coordinator any educational materials given to the member through these programs;
 - 2.8.10.4.4 Ensure that the care coordinator reviews Population Health educational materials verbally with the member and with the member's caregiver and/or representative (as applicable) and Coordinate follow-up that may be needed regarding the Population Health program, such as scheduling screenings or appointments with the CHOICES Care Coordinator;
 - 2.8.10.4.5 Ensure that the Care Coordinator integrates into the member's plan of care aspects of the Population Health Program that would help to better manage the member's condition; and
 - 2.8.10.4.6 Ensure that the member's care coordinator shall be responsible for coordinating with the member's providers regarding the development and implementation of an individualized treatment plan which shall be integrated into the member's plan of care and which shall include monitoring the member's condition, helping to ensure compliance with treatment protocols, and to the extent appropriate, lifestyle changes which will help to better ensure management of the member's condition (see Section 2.9.6 of this Agreement).
- 2.8.10.5 As part of a Population Health Program, the CONTRACTOR shall place CHOICES members into appropriate programs and/or stratification within a program, not only according to risk Level or other clinical or member-provided information but also by the type of setting in which long-term care services are delivered, i.e., nursing facility, community-based residential alternative, or home-based. The targeted interventions for CHOICES members should not only be based on risk level but also based on the setting in which the member resides.
- 2.8.10.5.1 Targeted methods for informing and educating CHOICES members shall not be limited to mailing educational materials;
- 2.8.10.6 The CONTRACTOR shall include CHOICES process data in quarterly and annual reports as indicated in Section 2.30.5 of this Agreement. CHOICES members will not be included in outcome measures in annual Population Health reports.
- 2.8.10.7 The CONTRACTOR shall ensure that upon a member's enrollment in CHOICES, if applicable, all High Risk Population Health Management CONTRACTOR activities are integrated with CHOICES care coordination processes and functions, and that the member's assigned care coordinator has primary responsibility for coordination of all the member's



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physical health, behavioral health, and long-term care needs. The care coordinator may use resources and staff from the CONTRACTOR's MCO Complex Case Management Program, including persons with specialized expertise in areas such as behavioral health, to supplement but not supplant the role and responsibilities of the member's care coordinator/care coordination team.

- 2.8.10.8 The CONTRACTOR, in addition to requirements pertaining to nursing facility to community transitions (see Section 2.9.6.8), members in CHOICES Group 1 who are under the age of 21 and who are residents of a nursing facility and have requested to transition home, shall provide coordination of care by the CHOICES Care Coordinator and the Population Health Complex Case Management staff:
 - 2.8.10.8.1 The member will be informed by CHOICES Care Coordinator of disenrollment from CHOICES upon discharge from Nursing Facility;
 - 2.8.10.8.2 Within three (3) business days of a request to transition by or on behalf of a Group 1 member under age 21, the member will be referred by the CHOICES Care Coordinator to MCO Case Management for service identification and implementation in the home setting;
 - 2.8.10.8.3 The Population Health Complex Case Manager will be responsible for developing a service plan for the home setting;
 - 2.8.10.8.4 The CHOICES Care Coordinator will communicate weekly via phone or face-to-face visits with the Population Health Complex Case Management staff, the member and/or the member's parent or guardian (as applicable and appropriate), and the nursing facility staff to ensure timely progression of the transition plan until it is determined that the transition is not appropriate or until the plan is complete; and
 - 2.8.10.8.5 Any EPSDT benefits needed by the child in the community as an alternative to nursing facility care, including medically necessary home health or private duty nursing, as applicable, shall be initiated immediately upon transition from a nursing facility (i.e., CHOICES Group 1) to the community and as of the effective date of transition with no gaps between the member's receipt of nursing facility services and EPSDT benefits.

2.8.11 Evaluation

- 2.8.11.1 The CONTRACTOR shall collect and report process and outcome data as indicated on Population Health quarterly and annual report templates provided by TENNCARE. Outcome data for these reports will include short, intermediate and long term measures.
- 2.8.11.2 The CONTRACTOR shall provide in the annual report for the programs, with interactive interventions, an active participation rate as designed by NCQA.
- 2.8.11.3 The CONTRACTOR shall evaluate and report member satisfaction based upon NCQA requirements, on Population Health programs with interactive interventions.
- 2.8.11.4 The CONTRACTOR shall assess member's functional status, using the SF12 survey, or other appropriate tool used for children or the intellectually disabled, for members in the high risk Chronic Care Management program and the Complex Case Management program.



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2.8.12 Special Projects

2.8.12.1 New Member mini Health Risk Assessments. The CONTRACTOR shall make reasonable attempts to assess member's health risks. Information such as weight, nutrition, substance abuse and physical inactivity collected from assessments will be used to align individual members with appropriate intervention approaches and maximize the impact of the services provided.

2.8.12.1.1 During 2013, the first year of implementation, the CONTRACTOR shall continue to conduct their current new member HRA and identify the method for incorporating HRA information into the identification system for eligibility into Population Health programs.

2.8.12.1.2 As appropriate, the CONTRACTOR's Population Health staff shall participate in a collaborative MCO/TennCare workgroup to identify a common standard new enrollee HRA and address innovative ways to improve member completion rates.

2.8.12.2 The CONTRACTOR shall conduct at least one rapid cycle improvement project annually. The rapid cycle improvement projects shall address increasing member engagement rates in the High Risk opt in level of Population Health programs. The project plan is to be reported in the quarterly report before implementation. The project should then be conducted with the results to be reported in the next Population Health Quarterly Report.

2.8.13 Milestones for the Sixth Month (January 1 to July 1, 2013) Transition Period from Disease Management to Population Health

2.8.13.1 The CONTRACTOR shall by January 1, 2013 stratify all members into the three risk categories described in Section 2.8.1.1.

2.8.13.2 The CONTRACTOR shall by March 31, 2013 have all disease management managed members receiving services at the end of the fourth quarter of 2012 transitioned to the new level 1 or level 2 Population Health programs.

2.8.13.3 The CONTRACTOR shall by January 31, 2013 have all members engaged in case management, at the end of the fourth quarter of 2012, transitioned to the appropriate Level 2 Population Health program.

2.8.13.4 The CONTRACTOR shall by April 30, 2013 have submitted all required operational data for the first three months of the transition period.

2.8.13.5 The CONTRACTOR shall by April 30, 2013 provide evidence in the quarterly Population Health Quarterly report, as cited above, that a method is in place to identify the targeted population for prenatal visit verification. (see Section 2.8.4.2.3)

2.8.13.6 The CONTRACTOR shall by July 1, 2013 have operationalized Population Health to provide all minimum interventions to enrollees who are not participating in a medical home lock in project, in the appropriate programs.

12. Section 2.9.5.3 shall be deleted in its entirety and the remaining Section 2.9.5 shall be renumbered accordingly, including any references thereto.



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13. Section 2.9.6.1.4 shall be amended by adding new language to the end of the existing language as follows:

2.9.6.1.4 Long-term care services identified through care coordination and provided by the CONTRACTOR shall build upon and not supplant a member's existing support system, including but not limited to informal supports provided by family and other caregivers, services that may be available at no cost to the member through other entities, and services that are reimbursable through other public or private funding sources, such as Medicare or long-term care insurance. However, once a member qualifies for CHOICES, he is no longer eligible to receive services under the State-funded Options program (see Rule 0030-2-1-.01), and neither the State nor the CONTRACTOR can require that services available to a member through CHOICES be provided instead through programs funded by Title III of the Older Americans Act.

14. Section 2.9.6.1.6 shall be deleted and replaced as follows:

2.9.6.1.6 The CONTRACTOR shall compute Care Coordination CHOICES-related timelines as follows;

2.9.6.1.6.1 The date of receipt of the referral by the CONTRACTOR (which shall not include any additional days for the CONTRACTOR to process the referral or assign to appropriate staff) shall be the anchor date for the referral process. The anchor date is not included in the calculation of days.

2.9.6.1.6.2 The anchor date for the enrollment process shall be the latter of 1) the date the Bureau transmits the 834 file to the CONTRACTOR; or 2) the date of CHOICES enrollment as indicated on the 834 file. The anchor date is not included in the calculation of days.

2.9.6.1.6.3 The Business Day (see Section 1) immediately following the anchor date is day one (1) of timelines utilizing business days. Each subsequent business day is included in the computation.

2.9.6.1.6.4 The calendar day immediately following the anchor date is day one (1) of timelines utilizing calendar days. Each subsequent calendar day is included in the computation.

15. Section 2.9.6.1.9 shall be deleted and replaced as follows:

2.9.6.1.9 The CONTRACTOR shall ensure that, upon enrollment into CHOICES, the appropriate level of Population Health (see Section 2.8.4 of this Agreement) activities are integrated with CHOICES care coordination processes and functions, and that the member's assigned care coordinator has primary responsibility for coordination of all the member's physical health, behavioral health, and long-term care needs. The care coordinator may use resources and staff from the CONTRACTOR's Population Health programs, including persons with specialized expertise in areas such as behavioral health, to supplement but not supplant the role and responsibilities of the care coordinator/care coordination team.



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16. Section 2.9.6.2.3 shall be deleted and replaced as follows and all references shall be updated accordingly.

2.9.6.2.3 Functions of the Single Point of Entry (SPOE)

2.9.6.2.3.1 For persons wishing to apply for CHOICES, TENNCARE or its designee may employ a screening process, using the tools and protocols specified by TENNCARE, to assist with intake for persons new to both TENNCARE and CHOICES. Such screening process shall assess: (1) whether the applicant appears to meet categorical and financial eligibility criteria for CHOICES, and (2) whether the applicant appears to meet level of care eligibility for enrollment in CHOICES.

2.9.6.2.3.2 For persons identified by TENNCARE or its designee as meeting the screening criteria, or for whom TENNCARE or its designee opts not to use a screening process, TENNCARE or its designee will conduct a face-to-face intake visit with the applicant. As part of this intake visit TENNCARE or its designee will, using the tools and protocols specified by TENNCARE, conduct a level of care and needs assessment; and assess the member's existing natural support system, including but not limited to informal supports provided by family and other caregivers, services that may be available at no cost to the member through other entities, and services that are reimbursable through other public or private funding sources, such as Medicare or long-term care insurance.

2.9.6.2.3.3 TENNCARE or its designee shall conduct the intake visit, including the level of care and needs assessment, in the applicant's place of residence, except under extenuating circumstances (such as the member's hospitalization), which shall be documented in writing.

2.9.6.2.3.4 As part of the intake visit, TENNCARE or its designee shall: (1) provide general CHOICES education and information, as specified by TENNCARE, and assist in answering any questions the applicant may have; (2) provide information about estate recovery; (3) complete Medicaid and level of care (i.e., PAE) applications and provide assistance, as necessary, in gathering documentation needed by the State to determine TENNCARE eligibility; (4) provide choice counseling and facilitate the selection of an MCO by the applicant or his/her representative; (5) for applicants seeking enrollment in CHOICES Group 1 or Group 2, provide information regarding freedom of choice of nursing facility versus CHOICES HCBS, both verbally and in writing, and obtain a Freedom of Choice form signed and dated by the applicant or his/her representative; (6) provide detailed information and obtain signed acknowledgement of understanding regarding a CHOICES member's responsibility with respect to payment of patient liability amounts, including, as applicable, the potential consequences for non-payment of patient liability which may include loss of the member's current nursing facility or CBRA provider or MCO, disenrollment from CHOICES, and to the extent the member's eligibility is dependent on receipt of long-term care services, possible loss of eligibility for TENNCARE; (7) for applicants who want to receive NF services, provide information regarding the completion of all PASRR requirements prior to nursing facility admission and conduct the level I PASRR screening; (8) for applicants who are seeking CHOICES HCBS: (a) conduct a risk assessment in accordance with protocols developed by TENNCARE and develop, as applicable, a risk agreement that shall be signed by the applicant or his/her representative which shall include identified risks to the applicant, the consequences of such risks, strategies to mitigate the identified risks, and the applicant's



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decision regarding his/her acceptance of risk; and (b) provide information regarding consumer direction and obtain signed documentation of the applicant's interest in participating in consumer direction; and (9) provide information regarding next steps in the process including the need for approval by TENNCARE to enroll in CHOICES and the functions of the CONTRACTOR, including that the CONTRACTOR will develop and approve a plan of care.

2.9.6.2.3.5 The State will be responsible for determining TennCare categorical and financial eligibility and level of care and enrolling eligible TennCare members into CHOICES.

2.9.6.2.3.6 TENNCARE will notify the CONTRACTOR via the outbound 834 enrollment file when a person has been enrolled in CHOICES, the member's CHOICES Group, and any applicable patient liability amounts (See Section 2.6.7). For members in CHOICES Group 2, TENNCARE will notify the CONTRACTOR of the member's cost neutrality cap (see definition in Section 1 and Section 2.6.1.5.2.3), which shall be the average cost of Level 1 nursing facility care unless a higher cost neutrality cap is established by TENNCARE based on information submitted by the AAAD or MCO (as applicable) in the level of care.

2.9.6.2.3.7 TENNCARE or its designee will make available to the CONTRACTOR the documentation from the intake visit, including but not limited to the member's level of care and needs assessment, the assessment of the member's existing natural support system, the member's risk assessment and documentation of the discussion regarding identified risk and mitigation strategies.

17. Section 2.9.6.2.5 shall be amended by adding new Sections 2.9.6.2.5.8 through 2.9.6.2.5.9.2 as follows and the remaining Section shall be renumbered accordingly, including any references thereto.

2.9.6.2.5.8 As part of the face-to-face visit for members in CHOICES Group 2, the Care Coordinator shall make a determination regarding whether the person's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care, and provide explanation to the member regarding the individual cost neutrality cap, including that a change in needs or circumstances that would result in the cost neutrality cap being exceeded or that would result in the CONTRACTOR's inability to safely and effectively meet the member's needs in the community and within the cost neutrality cap may result in the member's disenrollment from CHOICES Group 2, in which case, the member's care coordinator will assist with transition to a more appropriate care delivery setting;

2.9.6.2.5.8.1 If the Care Coordinator determines that the member's needs cannot be safely met in the community within the member's individual cost neutrality cap, the Care Coordinator shall assist the member in transitioning to a more appropriate care delivery setting, or if the member refuses, proceed with disenrollment from CHOICES.

2.9.6.2.5.9 As part of the face-to-face visit for members in CHOICES Group 3, the Care Coordinator shall provide explanation to the member regarding the fifteen thousand dollar (\$15,000) expenditure cap and make a determination whether the member's needs can be safely met within the array of services and supports that would be available if the applicant was enrolled in CHOICES Group 3, including CHOICES HCBS up to the expenditure cap of



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\$15,000, non-CHOICES HCBS available through TennCare (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers and make a determination whether the member's needs can be safely met within the array of services and supports that would be available if the applicant was enrolled in CHOICES Group 3, including CHOICES HCBS up to the expenditure cap of \$15,000, non-CHOICES HCBS available through TennCare (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers;

- 2.9.6.2.5.9.1 If the member has been conditionally enrolled into CHOICES Group 3 and is in a nursing facility, the Care Coordinator shall work with the nursing facility to coordinate timely transition to the community and initiation of CHOICES HCBS.
- 2.9.6.2.5.9.2 If the Care Coordinator determines that the member's needs cannot be safely met in the community within the array of services and supports that would be available as described in 2.9.6.5.9, the Care Coordinator shall, pursuant to protocols established by TENNCARE, coordinate with TENNCARE to review the member's level of care, and if nursing facility level of care is approved, to facilitate transition to CHOICES Group 1 or 2.

18. The renumbered Sections 2.9.6.2.5.10 and 11 shall be deleted and replaced as follows:

- 2.9.6.2.5.10 As part of the face-to-face visit for members in CHOICES Group 2 or Group 3, the care coordinator shall review, and revise as necessary, the member's risk assessment, develop a risk agreement, and have the member or his/her representative sign and date the risk agreement.
- 2.9.6.2.5.11 As part of the face-to-face visit, for members determined to need eligible CHOICES HCBS, the care coordinator shall verify the member's interest in participating in consumer direction and obtain written confirmation of the member's decision. The care coordinator shall also, using current information regarding the CONTRACTOR's network, provide member education regarding choice of contract providers for CHOICES HCBS, subject to the provider's availability and willingness to timely deliver services, and obtain signed confirmation of the member's choice of contract providers.

19. Section 2.9.6.3.1.3 shall be amended by deleting the phrase "DM MCO case management," and replacing it with "Population Health" as follows:

- 2.9.6.3.1.3 Referral from CONTRACTOR's staff including but not limited to Population Health and UM staff;

20. Section 2.9.6.3.1.5.4 shall be amended by deleting and replacing the word "DM" with the words "Population Health" as follows:

- 2.9.6.3.1.5.4 Data collected through the Population Health and/or UM processes.

21. Section 2.9.6.3.2 shall be amended by deleting and replacing the acronym "MOE" with the words "CHOICES At-Risk".



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22. Section 2.9.6.3.9 shall be deleted and replaced as follows:

2.9.6.3.9 As part of the face-to-face intake visit, the care coordinator shall: (1) provide general CHOICES education and information, as specified by TENNCARE, to the member and assist in answering questions the member may have; (2) provide information about estate recovery; (3) provide assistance, as necessary, in gathering documentation needed by DHS to determine categorical/financial eligibility for LTC; (4) for members seeking enrollment in CHOICES Group 1 or Group 2, provide information regarding freedom of choice of nursing facility versus CHOICES HCBS, both verbally and in writing, and obtain a Freedom of Choice form signed and dated by the member or his/her representative; (5) provide detailed information and signed acknowledgement of understanding regarding a CHOICES member's responsibility with respect to payment of patient liability amounts, including, as applicable, the potential consequences for non-payment of patient liability which may include loss of the member's current nursing facility or CBRA provider or MCO, disenrollment from CHOICES, and to the extent the member's eligibility is dependent on receipt of long-term care services, possible loss of eligibility for TennCare; and (6) for members who want to receive nursing facility services, provide information regarding the completion of all PASRR requirements prior to nursing facility admission and conduct the level I PASRR screening; (7) for members who are seeking CHOICES HCBS, the care coordinator, shall: (a) conduct a risk assessment using a tool and protocol specified by TENNCARE and shall develop, as applicable, a risk agreement that shall be signed and dated by the member or his/her representative and which shall include identified risks to the member, the consequences of such risks, strategies to mitigate the identified risks, and the member's decision regarding his/her acceptance of risk; and (b) provide information regarding consumer direction and obtain written confirmation of the member's decision regarding participation in consumer direction; (8) for members seeking enrollment in Group 2, make a determination regarding whether the person's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care, and provide explanation to the member regarding the individual cost neutrality cap, including that a change in needs or circumstances that would result in the cost neutrality cap being exceeded or that would result in the CONTRACTOR's inability to safely and effectively meet the member's needs in the community and within the cost neutrality cap may result in the member's disenrollment from CHOICES Group 2, in which case, the member's care coordinator will assist with transition to a more appropriate care delivery setting; (9) for members seeking enrollment in Group 3, provide explanation to the member regarding the fifteen thousand dollar (\$15,000) expenditure cap and make a determination whether the member's needs can be safely met within the array of services and supports that would be available if the applicant was enrolled in CHOICES Group 3, including CHOICES HCBS up to the expenditure cap of \$15,000, non-CHOICES HCBS available through TennCare (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers; and (10) for all members, using current information regarding the CONTRACTOR's network, provide information regarding choice of contract providers, subject to the provider's availability and willingness to timely deliver services, and obtain signed documentation of the member's choice of contract providers.

23. Section 2.9.6.5.1.1 shall be amended by deleting and replacing the words "disease management" with "Population Health".



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24. Section 2.9.6.6.1.1 shall be amended by deleting and replacing the words “disease management” with “Population Health”.
25. Section 2.9.6.8.2 shall be amended by deleting and replacing the words “MCO Case Management” with “Population Health” and updating the reference to Section “2.9.5.4.1” with “2.9.5.3.1”.
26. The first sentence of Section 2.9.6.8.7 shall be amended by deleting the phrase “using a tool and protocol specified” and replacing it with the phrase “in accordance with protocols developed”.
27. Section 2.9.6.9.1.1.2 shall be amended by deleting and replacing the words “disease management” with “Population Health”.
28. Section 2.9.6.9.3.1 shall be amended by deleting and replacing Section 2.9.6.9.3.1.1.1 and adding new Sections 2.9.6.9.3.1.1.3 through 2.9.6.9.3.1.1.3.2 as follows:
 - 2.9.6.9.3.1.1.1 If the level of care assessment indicates a change in the level of care, or if the assessment was prompted by a request by a member, a member’s representative or caregiver or another entity for a change in level of services, the level of care shall be forwarded to TENNCARE for determination;
 - 2.9.6.9.3.1.1.3 For all persons enrolled into the CHOICES program (CHOICES Group 1 or 2) prior to implementation of the new NF Level of Care (LOC) criteria on July 1, 2012, the CONTRACTOR shall be obligated to assess the person’s LOC as follows:
 - 2.9.6.9.3.1.1.3.1 The CONTRACTOR shall, for purposes of LOC eligibility to remain in the CHOICES Group in which the member is enrolled, assess the member’s LOC eligibility be based on the criteria in place at the time of the member’s enrollment into that CHOICES group.
 - 2.9.6.9.3.1.1.3.2 The CONTRACTOR shall also, for purposes of complying with the Terms and Conditions of the State’s Waiver, assess the member’s LOC eligibility based on the new LOC criteria in place as of July 1, 2012. The CONTRACTOR shall report the results of the LOC reassessment to TENNCARE. This information will be used by the State in its expenditure reporting to CMS.
29. Section 2.9.6.9.3.3 shall be amended by deleting and replacing the words “disease management” with “Population Health”.
30. The third sentence in Section 2.9.6.10.9 shall be amended by deleting the phrase “as applicable,” between the words “agreement” and “shall” as follows:
 - 2.9.6.10.9 For members electing to participate in consumer direction, the member’s care coordinator shall develop and/or update risk agreement which takes into account the member’s decision to participate in consumer direction, and which identifies any additional risks associated with the member’s decision to direct his/her services, the potential consequences of such risk, as



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well as measures to mitigate these risks. The member's representative (if applicable) shall participate in the risk assessment process. The new or updated risk agreement, shall be signed by the member (or the member's representative, as applicable). The CONTRACTOR shall provide a copy of the risk agreement to the member/representative and the FEA.

31. **Section 2.9.6.11.18.21 shall be amended by deleting and replacing the words "disease management" with "Population Health".**
32. **Section 2.9.6.11.18 shall be amended by adding new Sections 2.9.6.11.18.32 through 2.9.6.11.18.35 as follows:**
 - 2.9.6.11.18.32 The Care Coordinator's role and responsibility in implementing the Advance Determination process including qualifying criteria, when the process may be implemented, and what documentation must be presented to support the determination pursuant to TENNCARE rule 12 13 01-05.
 - 2.9.6.11.18.33 The Care Coordinator's role and responsibility in assessing members who have been conditionally enrolled into CHOICES and coordination with the nursing facility to facilitate timely transition, when appropriate.
 - 2.9.6.11.18.34 The Care Coordinator's role and responsibility in facilitating denial of enrollment into or termination of enrollment from CHOICES Groups 2 or 3 when a determination has been made that the applicant or member (as applicable) cannot be safely served within the member's cost neutrality cap (CHOICES Group 2) or Expenditure Cap (CHOICES Group 3).
 - 2.9.6.11.18.35 The Care Coordinator's role and responsibility in facilitating access to other medically TennCare covered benefits, including home health and behavioral health services.
33. **The fifth paragraph in Section 2.9.7.4.10.10 shall be amended by deleting the phrase "as applicable," between the words "agreement" and "shall" as follows:**
 - 2.9.7.4.10.10 The CONTRACTOR shall develop and/or update risk agreement which takes into account the member's decision to participate in consumer direction, and which identifies any additional risks associated with the member's decision to direct his/her services, the potential consequences of such risk, as well as measures to mitigate these risks. The member/representative shall participate in the process. The member's representative (if applicable) shall participate in the risk assessment process. Once a referral has been made to the FEA for consumer direction, the member's supports broker should be involved in risk assessment and risk planning activities whenever possible. The new or updated risk agreement shall be signed by the member or his/her representative (as applicable). The CONTRACTOR, member/representative and FEA shall receive a copy of the risk agreement. The CONTRACTOR and the FEA shall each file a copy of the risk agreement in the member's file
34. **Section 2.9.8.3.6 shall be amended by deleting and replacing the word "Tennessee" with the word "TENNCARE".**



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35. Section 2.9.8.8.1 shall be amended by adding a new Section 2.9.8.8.1.1 as follows:

2.9.8.8.1.1 The ninety (90) day limit shall be applied on a per admission (and not a per year) basis. A member may receive more than one short-term stay during the year. However, the CONTRACTOR shall be responsible for carefully reviewing any instance in which a member receives multiple short-term stays during the year or across multiple years, including a review of the circumstances which resulted in each nursing facility admission, and shall evaluate whether the services and supports provided to the member are sufficient to safely meet his needs in the community such that transition back to CHOICES Group 2 or Group 3 (as applicable) is appropriate.

36. Section 2.9.9.1 shall be deleted and replaced as follows:

2.9.9.1 General

As provided in Section 2.6.1 of this Agreement, the CONTRACTOR shall be responsible for providing a full continuum of physical health, behavioral health, and long-term care services. The CONTRACTOR shall also be responsible for ensuring continuity and coordination between covered physical health, behavioral health, and long-term care services and ensuring collaboration between physical health, behavioral health, and long-term care providers. The CONTRACTOR shall develop policies and procedures that address key elements in meeting this requirement. These elements include, but are not limited to, screening for behavioral health needs (including the screening tool), referral to physical health and behavioral health providers, screening for long-term care needs, exchange of information, confidentiality, assessment, treatment plan and plan of care development and implementation, collaboration, , care coordination (for CHOICES members) and Population Health, provider training, and monitoring implementation and outcomes.

37. Section 2.9.9.8 shall be deleted and replaced as follows:

2.9.9.8 Population Health and CHOICES Care Coordination

The CONTRACTOR shall use its Population Health, and CHOICES care coordination programs (see Sections 2.9.5, 2.8, and 2.9.6) to support the continuity and coordination of covered physical health, behavioral health, and long-term care services and the collaboration between physical health, behavioral health, and long-term care providers. The CONTRACTOR has the option to allow members, e.g., members who have been determined to be high risk based on Population Health stratification (see Section 2.8.3), to be enrolled in an appropriate level Population Health Program (see Section 2.8.4 of this Agreement). For CHOICES members, Population Health activities shall be integrated with the care coordination process (see Sections 2.9.5.3, and 2.9.6.1.9).



Amendment 30 (cont.)

38. Section 2.9.11.3.1 shall be deleted and replaced as follows:

2.9.11.3.1 Analyzing prescription drug data and/or reports provided by the PBM or TENNCARE to identify high-utilizers and other members who inappropriately use pharmacy services and assign them to Population Health programs and/or refer them to CHOICES intake (see Section 2.9.6) as appropriate; if a CHOICES member is identified as a high-utilizer or as inappropriately using pharmacy services, relevant prescription drug data and/or reports for the member shall be provided to the member's care coordinator, and the care coordinator shall take appropriate next steps, which may include coordination with the member's PCP

39. Section 2.9 shall be amended by adding a new 2.9.14 as follows and renumbering the remaining Section accordingly, including any references thereto.

2.9.14 Coordination with Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) regarding the CONTRACTOR's Full Benefit Dual Eligible (FBDE) Members Enrolled in a D-SNP

2.9.14.1 The CONTRACTOR shall modify its IT systems to accept Medicare enrollment data and to load the data in the CONTRACTOR's case management system for use by Care Coordinators and case management, DM/Population Health and UM staff.

2.9.14.2 The CONTRACTOR shall coordinate with a FBDE member's D-SNP regarding discharge planning from any inpatient setting when Medicaid LTSS (NF or HCBS), Medicaid home health or private duty nursing, or other Medicaid services may be needed upon discharge in order to ensure that care is provided in the most appropriate, cost effective and integrated setting.

2.9.14.2.1 The CONTRACTOR shall develop, for review and approval by TENNCARE, policies, procedures and training for CONTRACTOR staff, including Care Coordinators, regarding coordination with a FBDE member's D-SNP in discharge planning from an inpatient setting to the most appropriate, cost effective and integrated setting.

2.9.14.2.2 The CONTRACTOR shall receive and process in a timely manner a standardized electronic Daily Inpatient Admissions, Census and Discharge Report, from each D-SNP operating in the Grand Region served by the CONTRACTOR.

2.9.14.2.3 The CONTRACTOR shall provide a technical contact to address any technical problems in the submission of the daily Report.

2.9.14.2.4 The CONTRACTOR shall establish processes to ensure that notifications of inpatient admission are timely and appropriately triaged.

2.9.14.2.5 The CONTRACTOR shall establish tracking mechanisms to ensure that staff are timely and appropriately engaged in discharge planning, and for CHOICES members, that Care Coordinators are notified/engaged as appropriate.

2.9.14.2.6 The CONTRACTOR shall maintain daily reports for audit to determine appropriate and timely engagement in discharge planning.



Amendment 30 (cont.)

- 2.9.14.3 The CONTRACTOR shall coordinate with a FBDE member's D-SNP regarding CHOICES LTSS that may be needed by the member; however, the D-SNP shall remain responsible for ensuring access to all Medicare benefits covered by the CONTRACTOR, including SNF and home health, and shall not supplant such medically necessary covered services with services available only through TennCare.
- 2.9.14.3.1 The CONTRACTOR shall develop, for review and approval by TENNCARE prior to their implementation, policies, procedures and training for processing in a timely manner requests for CHOICES LTSS from a FBDE member's D-SNP, including communication with the member's Care Coordinator and/or UM staff, response to the D-SNP submitter, collaboration between the Medical Director(s) of the D-SNP and MCO regarding medical necessity denials, and escalation procedures/contacts.
- 2.9.14.4 The CONTRACTOR shall coordinate with a FBDE member's D-SNP to ensure timely access to medically necessary covered Medicare benefits needed by a FBDE member, including members enrolled in the CHOICES program.
- 2.9.14.4.1 The CONTRACTOR shall develop, for review and approval by TENNCARE prior to their implementation, policies, procedures and training for staff, including Care Coordinators, regarding service requests to a FBDE member's D-SNP for Medicare benefits needed by the member.
- 2.9.14.5 The CONTRACTOR shall request, when appropriate, the D-SNP's participation in needs assessments and/or the development of an integrated person-centered plan of care for a TennCare CHOICES member, encompassing Medicare benefits provided by the CONTRACTOR as well as Medicaid benefits provided by the TennCare MCO.
- 2.9.14.5.1 The CONTRACTOR shall develop, for review and approval by TENNCARE prior to their implementation, policies, procedures, and training for engaging D-SNP participation in the CHOICES needs assessment/care planning process for a FBDE member, including the roles/responsibilities of the TennCare MCO and the D-SNP.
- 2.9.14.6 The CONTRACTOR shall submit to a FBDE member's D-SNP, as applicable and appropriate, referrals for case management and/or disease management/Population Health.
- 2.9.14.6.1 The CONTRACTOR shall develop, for review and approval by TENNCARE prior to their implementation, policies procedures and training for staff regarding the D-SNP case management and/or disease management/Population Health referral process.
- 2.9.14.7 The CONTRACTOR shall coordinate with each D-SNP operating in the Grand Region served by the CONTRACTOR and with the D-SNP's providers (including hospitals and physicians) in the CONTRACTOR's implementation of its nursing facility diversion program.
- 2.9.14.7.1 The CONTRACTOR shall provide to D-SNPs training on the CONTRACTOR's NF Diversion program, including the referral process.
- 2.9.14.7.2 The CONTRACTOR shall, pursuant to Section 2.9.6, accept and process from a member's D-SNP a referral for HCBS in order to delay or prevent NF placement.



Amendment 30 (cont.)

- 2.9.14.8 The CONTRACTOR shall, pursuant to Section 2.9.6 receive and process from a FBDE member's D-SNP a referral for transition from a SNF to the community, and shall coordinate with the FBDE member's D-SNP to facilitate timely transition, as appropriate, including coordination of services covered by the CONTRACTOR and services covered by the D-SNP.
- 2.9.14.8.1 The CONTRACTOR shall provide to D-SNPs training on the CONTRACTOR's NF-to-community transition program, including the referral, screening and assessment process.
- 2.9.14.9 The CONTRACTOR shall participate, as appropriate, in D-SNP training regarding D-SNP responsibilities for coordination of Medicare and Medicaid benefits for FBDE members and benefits covered under the TennCare program, including CHOICES.

40. Section 2.11.1.3 shall be amended by adding a new Section 2.11.1.3.7 as follows:

- 2.11.1.3.7 Not discriminate against providers and entities in accordance with the federal prohibition against discrimination as provided for under the collective "federal health care provider conscience protection statutes," referenced individually as the Church Amendments, 42 U.S.C. § 300a-7, section 245 of the Public Health Service Act, 42 U.S.C. § 238n, and the Weldon Amendment, Consolidated Appropriations Act, 2010, Public Law 111-117, Div. D, Sec. 508(d), 123 Stat. 3034, 3279-80.

41. Section 2.11.6.1 shall be deleted and replaced in its entirety.

- 2.11.6.1 The CONTRACTOR shall contract with all current nursing facilities (as defined in TCA 71-5-1412(b)), that meet all CMS certification requirements, for a minimum of three (3) years following the effective date of CHOICES implementation. Pursuant to Public Chapter 971, such period is extended through June 30, 2015 if the facility is willing to contract with the CONTRACTOR under the same terms and conditions offered to any other participating facility; however this does not prevent the CONTRACTOR from enforcing the provisions of its contract with the facility. Thereafter, the CONTRACTOR shall contract with a sufficient number of nursing facilities in order to have adequate capacity to meet the needs of CHOICES members for nursing facility services

42. Section 2.11.6 shall be amended by deleting and replacing Section 2.11.6.7 and by adding a new Section 2.11.6.8 as follows:

- 2.11.6.7 The CONTRACTOR shall assist in developing an adequate qualified workforce for covered long-term care services. The CONTRACTOR shall actively participate with TENNCARE, other TennCare managed care contractors, and other stakeholders as part of a statewide initiative to develop and implement strategies to increase the pool of available qualified direct care staff and to improve retention of qualified direct care staff. The strategies may include, for example, establishing partnerships with local colleges and technical training schools to develop and implement training and/or certification programs for direct support staff; creating a registry of trained and/or certified staff with the ability to match people who need assistance with staff to provide such assistance based on individualized needs and preferences; providing incentives for providers who employ specially trained and/or certified staff and who assign staff based on member needs and preferences; and systems to encourage direct support staff to engage as an active participant in the care coordination team. The CONTRACTOR's active participation in this statewide initiative shall fulfill its obligation under this section; however the CONTRACTOR is not prohibited for pursuing additional



Amendment 30 (cont.)

workforce development activities. The CONTRACTOR shall report annually to TENNCARE on the status of any additional qualified workforce development strategies it elects to implement (see Section 2.30.8.7)

2.11.6.8 TENNCARE will evaluate the need for further action when the above standards are not met. At its sole discretion TENNCARE may elect one of three options: (1) TENNCARE may request a Corrective Action Plan (CAP), (2) a Request for Information (RFI), (3) or an On Request Report (ORR) depending on the severity of the deficiency.

2.11.6.8.1 The requested CAP, RFI or ORR response shall detail the CONTRACTOR's network adequacy considering any alternate measures, documentation of unique market conditions and/or its plan for correction. If TENNCARE determines the CONTRACTOR's response demonstrates the existence of alternate measures or unique market conditions, TENNCARE may elect to request periodic updates from the CONTRACTOR regarding efforts to address such conditions.

43. Section 2.12.9.4 shall be deleted and replaced as follows:

2.12.9.4 Failure by the provider to obtain written approval from the CONTRACTOR for a subcontract that is for the purposes of providing TennCare covered services may lead to the contract being declared null and void at the option of TENNCARE. Claims submitted by the subcontractor or by the provider for services furnished by the subcontractor are considered to be improper payments and may be considered false claims. Any such improper payments may be subject to action under Federal and State false claims statutes or be subject to be recouped by the CONTRACTOR and/or TENNCARE as overpayment;

44. Section 2.12.9.61 shall be amended by adding the words "public" and "in English and Spanish" as follows:

2.12.9.61 Require that the provider display public notices of the enrollee's right to appeal adverse action affecting services in public areas of their facility(s) in accordance with TennCare rules and regulations, subsequent amendments, or any and all consent decrees and court orders. The CONTRACTOR shall ensure that providers have a correct and adequate supply of public notices in English and Spanish;

45. Section 2.12.9.65 shall be deleted and replaced as follows:

2.12.9.65 Specify that the provider agreements include the following nondiscrimination provisions:

2.12.9.65.1 Language that no person on the grounds of handicap, and/or disability, age, race, color, religion, sex, or national origin shall be excluded from participation in, except as specified in Section 2.3.5, or be denied benefits of, or be otherwise subjected to discrimination in the performance of provider's obligation under its agreement with the CONTRACTOR or in the employment practices of the provider.

2.12.9.65.2 Specify that the provider have written procedures for the provision of language interpretation and translation services for any enrollee who needs such services, including but not limited to, enrollees with Limited English Proficiency.



Amendment 30 (cont.)

2.12.9.65.3 Require the provider to agree to cooperate with TENNCARE and the CONTRACTOR during discrimination complaint investigations.

2.12.9.65.4 Require the provider to assist TennCare enrollees in obtaining discrimination complaint forms and contact information for the CONTRACTOR's Nondiscrimination Office.

46. Section 2.13.9 shall be deleted and replaced in its entirety and shall read as follows:

2.13.9 Medicaid Payment for Primary Care

2.13.9.1 In accordance with the Patient Protection and Affordable Care Act of 2010 (The Affordable Care Act), for calendar years 2013 and 2014, the CONTRACTOR shall make payments for certain primary care services (as described by CMS) and furnished by primary care providers (as described by CMS and TENNCARE) in an amount that has been determined by CMS.

2.13.9.2 In addition to the routine claims payment reports required by this Agreement, the CONTRACTOR shall report to TENNCARE any information related to this requirement in a format described by TENNCARE.

47. Sections 2.14.1.16.2 and 2.14.1.16.5 shall be deleted and replaced as follows:

2.14.1.16.2 Enroll non-CHOICES members whose utilization exceeds the threshold of ED visits defined by TENNCARE in the previous six (6) month period in the appropriate level of Population Health services (see Section 2.8.4 of this Agreement) and may use the information to identify members who may be eligible for CHOICES in accordance with the requirements in Section 2.9.6.3 if appropriate;

2.14.1.16.5 Assess the most likely cause of high utilization and develop a Population Health Complex Case Management (see Section 2.8.4 of this Agreement) plan based on results of the assessment for each non-CHOICES member.

48. Section 2.14.2.3 shall be deleted and replaced as follows:

2.14.2.3 Prior authorization requests shall be processed in accordance with 42 CFR § 438.210(d) and the guidelines described in TennCare rules and regulations which include, but are not limited to, provisions regarding decisions, notices, medical contraindication, and the failure of an MCO to act timely upon a request. Instances in which an enrollee's health condition shall be deemed to require an expedited authorization decision by the CONTRACTOR shall include requests for home health services for enrollees being discharged from a hospital or other inpatient setting when such home health services are needed to begin upon discharge.

49. Section 2.14.3.5.2 shall be amended by adding the words "hard copy" as follows:

2.14.3.5.2 The referral provider listing shall be in the format specified by TENNCARE for the hard copy provider directory in Section 2.17.8.



Amendment 30 (cont.)

- 50. Section 2.14.5 shall be amended by adding a new Section 2.14.5.5 as follows and the remaining Section shall be renumbered accordingly including any references thereto.**

2.14.5.5 The CONTRACTOR may determine the duration of time for which CHOICES HCBS will be authorized. However, the CONTRACTOR shall be responsible for monitoring its authorizations and for ensuring that there are no gaps in authorizations for CHOICES HCBS in accordance with the plan of care. Retroactive entry or adjustments in service authorizations for CHOICES HCBS should be made only when required to accommodate payment of services that had been authorized but an adjustment in the schedule of services was required based on the member's needs.

- 51. Section 2.14.9.3 shall be deleted and replaced as follows:**

2.14.9.3 Emergency Room Utilization

The CONTRACTOR shall maintain a procedure to identify and evaluate member emergency room utilization by PCP panel. As provided in Section 2.14.1.16 of this Agreement, members who establish a pattern of accessing emergency room services shall be referred to the appropriate Population Health Program for follow-up services.

- 52. Section 2.15.1.6 shall be amended by adding a new Section 2.15.1.6.2 as follows and renumbering the remaining Sections accordingly including any references thereto.**

2.15.1.6.2 The CONTRACTOR shall participate in workgroups and agree to establish and implement policies and procedures, including billing and reimbursement, that are agreed to and/or described by TENNCARE in order to address specific quality concerns. These initiatives shall include but not be limited to identification of prenatal and postpartum visits in a time effective manner especially when a provider bills for total obstetrical care using a global billing code.

- 53. Section 2.15.3.1.1 shall be deleted and replaced as follows:**

2.15.3.1.1 The two (2) clinical PIPs shall include one (1) in the area of behavioral health that is relevant to one of the Population Health programs for bipolar disorder, major depression, or schizophrenia and one (1) in the area of either child health or perinatal (prenatal/postpartum) health.

- 54. Section 2.15.4 shall be deleted and replaced as follows:**

2.15.4 Clinical Practice Guidelines

The CONTRACTOR shall utilize evidence-based clinical practice guidelines in its Population Health Programs (see Section 2.8.6 of this Agreement). The guidelines shall be reviewed and revised whenever the guidelines change and at least every two (2) years. The CONTRACTOR is required to maintain an archive of its clinical practice guidelines for a period of five (5) years. Such archive shall contain each clinical guideline as originally issued so that the actual guidelines for prior years are retained for Program Integrity purposes.



Amendment 30 (cont.)

55. Section 2.15.6.1.1 shall be amended by adding a new sentence at the end of the existing text as follows:

2.15.6.1.1 Beginning with HEDIS 2012, the CONTRACTOR shall utilize the Hybrid methodology (i.e., gathered from administrative and medical record data) as the data collection method for any Medicaid HEDIS measure containing Hybrid Specifications as identified by NCQA. If, in the event the CONTRACTOR fails to pass the medical record review for any given standard and NCQA *mandates* administrative data must be submitted instead of hybrid, the administrative data may be used.

56. Section 2.15.7.1.3 shall be amended by deleting and replacing Section 2.15.7.1.3.3, adding a new Section 2.15.7.1.3.4 and renumbering the existing Section accordingly including any references thereto.

2.15.7.1.3.3 Theft against a CHOICES member;

2.15.7.1.3.4 Financial exploitation of a CHOICES member;

57. Section 2.17.5.2 through 2.17.5.2.1.1.3 shall be deleted and replaced as follows:

2.17.5.2 Teen Newsletter

The CONTRACTOR shall, at a minimum, distribute on a quarterly basis a newsletter to all enrollees between the ages of 15 and 20 which is intended to educate the enrollee to the managed care system, proper utilization of services, etc., with an emphasis on the encouragement to utilize TENNderCare services.

2.17.5.2.1 The Teen Newsletter shall be a product of the TENNderCare MCC Collaborative. The MCOs will agree on five required topics to include in each newsletter. MCOs may include additional articles at their discretion; no deviation from the five agreed upon articles will be allowed unless approved in writing by TENNCARE.

2.17.5.2.1.1 The CONTRACTOR shall include the following information in each newsletter:

2.17.5.2.1.1.1 The procedure on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free; and

2.17.5.2.1.1.2 TENNderCare information, including but not limited to, encouragement to obtain screenings and other preventive care services.



Amendment 30 (cont.)

58. Section 2.17.8 shall be deleted and replaced as follows:

2.17.8 Provider Directories

- 2.17.8.1 The CONTRACTOR shall distribute information regarding general provider directories (see Section 2.17.8.5 below) to new members within thirty (30) calendar days of receipt of notification of enrollment in the CONTRACTOR's MCO or prior to the member's enrollment effective date. Such information shall include how to access the provider directory, including the right to request a hard copy and to contact the CONTRACTOR's member services line to inquire regarding a provider's participation in the CONTRACTOR's network. Members receiving a hard copy of the provider directory shall be advised that the CONTRACTOR's network may have changed since the directory was printed, and how to access current information regarding the CONTRACTOR's participating providers.
- 2.17.8.2 The CONTRACTOR shall provide information regarding the CHOICES provider directory (see Section 2.17.8.6 below) to each CHOICES member as part of the face-to-face visit (for members enrolled through the SPOE) or face-to-face intake visit (for current members) as applicable, but not more than thirty (30) days from notice of CHOICES enrollment. Such information shall include how to access the CHOICES provider directory, including the right to request a hard copy and to contact the CONTRACTOR's member services line to inquire regarding a provider's participation in the CONTRACTOR's network. Members receiving a hard copy of the CHOICES provider directory shall be advised that the CONTRACTOR's network may have changed since the directory was printed, and how to access current information regarding the CONTRACTOR's participating providers.
- 2.17.8.3 The CONTRACTOR shall also be responsible for maintaining updated provider information in an online searchable electronic general provider directory and an online searchable electronic CHOICES provider directory. A PDF copy of the hard copy version shall not meet this requirement. The online searchable version of the general provider directory and the CHOICES provider directory shall be updated on a daily basis during the business week. In addition, the CONTRACTOR shall make available upon request, in hard copy format, a complete and updated general provider directory to all members and an updated CHOICES provider directory to CHOICES members. The hard copy of the general provider directory and the CHOICES provider directory shall be updated at least on an annual basis. Members receiving a hard copy and/or accessing a PDF version of the hard copy on the CONTRACTOR's website of the general provider directory or the CHOICES provider directory shall be advised that the CONTRACTOR's network may have changed since the directory was printed, and how to access current information regarding the CONTRACTOR's participating providers, including the searchable electronic version of the general provider directory and the CHOICES provider directory and the CONTRACTOR's member services line.
- 2.17.8.4 Provider directories (including both the general provider directory and the CHOICES provider directory), and any revisions thereto, shall be submitted to TENNCARE for written approval prior to distribution to enrollees in accordance with Section 2.17.1 of this Agreement. The text of the directory shall be in the format prescribed by TENNCARE. In addition, the provider information used to populate the provider directory shall be submitted as a TXT file or such format as otherwise approved in writing by TENNCARE and be produced using the same extract process as the actual provider directory.



Amendment 30 (cont.)

- 2.17.8.5 The CONTRACTOR shall develop and maintain a general provider directory, which shall be made available to all members. The provider directory shall be posted on the CONTRACTOR's website, and provided in hard copy upon request of the member. Members shall be advised in writing regarding how to access the provider directory, including the right to request a hard copy and to contact the CONTRACTOR's member services line to inquire regarding a provider's participation in the CONTRACTOR's network. Members receiving a hard copy of the provider directory shall be advised that the CONTRACTOR's network may have changed since the directory was printed, and how to access current information regarding the CONTRACTOR's participating providers. The online version of the provider directory shall be updated on a daily basis. The general provider directory shall include the following: names, locations, telephone numbers, office hours, and non-English languages spoken by contract PCPs and specialists; identification of providers accepting new patients; and identification of whether or not a provider performs TENNderCare screens; hospital listings, including locations of emergency settings and post-stabilization services, with the name, location, and telephone number of each facility/setting; and a prominent notice that CHOICES members should refer to the CHOICES provider directory for information on long-term care providers.
- 2.17.8.6 The CONTRACTOR shall develop and maintain a CHOICES provider directory that includes long-term care providers. The CHOICES provider directory, which shall be made available to all CHOICES members, shall include the following: nursing facility listings with the name, location, and telephone number of each facility; community-based residential alternatives, by type, with the name, location, and telephone number of each facility; and a listing of other (non-residential) CHOICES HCBS providers with the name, location, telephone number, and type of services by county of each provider. The CHOICES provider directory shall be posted on the CONTRACTOR's website, and provided in hard copy upon request of the member. Members shall be advised in writing regarding how to access the CHOICES provider directory, including the right to request a hard copy and to contact the CONTRACTOR's member services line to inquire regarding a provider's participation in the CONTRACTOR's network. Members receiving a hard copy of the CHOICES provider directory shall be advised that the CONTRACTOR's network may have changed since the directory was printed, and how to access current information regarding the CONTRACTOR's participating providers. The online version of the CHOICES provider directory shall be updated on a daily basis.



Amendment 30 (cont.)

59. Section 2.18.2 shall be deleted and replaced as follows:

2.18.2 Interpreter and Translation Services

- 2.18.2.1 The CONTRACTOR shall develop written policies and procedures for the provision of language interpreter and translation services, including effective communication assistance in alternative formats, such as, auxiliary aids to any member who needs such services. The CONTRACTOR shall provide language and cultural competence training to subcontractors and contracted providers which shall include the potential impact of linguistic and cultural barriers on utilization, quality and satisfaction with care and how and when to access interpreter services and to promote their appropriate use during the medical encounter.
- 2.18.2.2 The CONTRACTOR shall provide language interpreter and translation services including effective communication assistance in alternative formats, such as, auxiliary aids free of charge to members.
- 2.18.2.3 Interpreter services should be available in the form of in-person interpreters, sign language or access to telephonic assistance, such as the ATT universal line.

60. Section 2.18.6 shall be amended by adding a new Section 2.18.6.13 and renumbering the remaining Section accordingly, including any references thereto. The renumbered Section 2.18.6.14 shall be deleted and replaced as follows:

- 2.18.6.13 The CONTRACTOR shall submit all general correspondence intended for mass distribution that affects provider reimbursement, claims processing procedures, or documents that are referenced as a part of a CONTRACTOR's provider agreement template(s) (see Section 2.12.2) to TDCI for review and approval or acceptance, as appropriate (e.g., provider handbooks, newsletters, alerts, notices, reminders, other education material, etc.).
- 2.18.6.14 The CONTRACTOR's provider relations staff shall contact all contract providers on a semi-annual basis to update contract providers on CONTRACTOR initiatives and communicate pertinent information to contract providers. For providers located in Tennessee and out-of-state providers located in contiguous counties, at least one of the two semi-annual contacts made in a year shall be face-to-face with the provider. Semi-annual contacts that are not conducted face-to-face shall be conducted via a phone conversation with the provider. The CONTRACTOR shall maintain records that provide evidence of compliance with the requirement in this Section 2.18.6.14, including when and how contact is made for each contract provider. The CONTRACTOR may submit an alternative plan to accomplish the intent of this requirement for review and approval by TENNCARE.



Amendment 30 (cont.)

- 61. Section 2.20.2.4 shall be amended by adding the word “tips,” in front of the word “confirmed” and by adding a new Section 2.20.2.4.1 and renumbering the remaining Section accordingly, including any references thereto.**

2.20.2.4 The CONTRACTOR shall report all tips, confirmed or suspected fraud and abuse to TENNCARE and the appropriate agency as follows:

2.20.2.4.1 All tips (any program integrity case opened within the previous two (2) weeks) shall be reported to TennCare Office of Program Integrity and TBI MFCU;

- 62. Section 2.22.4 shall be amended by adding new Sections 2.22.4.11 through 2.22.4.12 as follows:**

2.22.4.11 For purposes of timely filing (see Section 2.12.9.28):

2.22.4.11.1 For institutional claims that include span dates of service (i.e., a 'From' and 'Through' date on the claim), the 'Through' date on the claim shall be used for determining the date of service for claims filing timeliness. The CONTRACTOR shall provide a minimum of sixty (60) days from the date of initial notice of an invalid and/or insufficient claim or one hundred twenty (120) days from the date of service or “Through” date on a span bill, whichever is later, for submission of a valid, complete claim.

2.22.4.11.2 For claims submitted by physicians and other suppliers that include span dates of service, the line item 'From' date shall be used for determining the date of service for claims filing timeliness. The CONTRACTOR shall provide a minimum of sixty (60) days from the date of initial notice of an invalid and/or insufficient claim or one hundred twenty (120) days from the date of service or “Through” date on a span bill, whichever is later, for submission of a valid, complete claim.

2.22.4.11.3 For claims submitted by physicians and other suppliers that do not include span dates of service, the date of service shall be used for determining claims filing timeliness. The CONTRACTOR shall provide a minimum of sixty (60) days from the date of initial notice of an invalid and/or insufficient claim or one hundred twenty (120) days from the date of service, whichever is later, for submission of a valid, complete claim.

2.22.4.11.4 Beginning with claims for dates of service January 1, 2013 and following, except for 1) recovery of overpayments as required pursuant to Section 6402 of the Affordable Care Act and TENNCARE policy; and 2) retrospective adjustments of a nursing facility’s per diem rate(s) (see Section 2.13.3.4), paid claims requiring correction or resubmission must be submitted as adjustments to the paid claim within 120 days of the date of payment notification. Corrections to a claim should only be submitted if the original claim information was wrong or incomplete.



Amendment 30 (cont.)

2.22.4.11.5 The provider has the right to file a dispute if he or she disagrees with a claim decision regarding the denial or compensation of a claim in accordance with section (2.12.9.)

2.22.4.11.6 The CONTRACTOR shall specify in its provider manual a period of time that is consistent with these requirements and to the extent that this reflects a change in the CONTRACTOR's current provider manual, shall issue notification to providers on or before January 2, 2013.

2.22.4.12 The CONTRACTOR shall, for a period to be determined by TENNCARE, permit CHOICES Nursing Facility and HCBS providers to resubmit and shall process any institutional or HCBS claims for dates of service on or after March 1, 2010, that were denied on the basis of timely filing when the claim was filed in accordance with 2.22.4.11.1, 2.22.4.11.2, or 2.22.4.11.3, as applicable, or for which the applicable minimum reprocessing time was not provided.

63. Section 2.23.4.3.7 shall be amended by adding the phrase (see Section 2.30.18.3) in the last sentence.

64. Section 2.23.5.2 shall be deleted and replaced as follows:

2.23.5.2 The CONTRACTOR shall systematically update its eligibility/enrollment databases within twenty-four (24) hours of receipt of said files. Any outbound 834 transactions which fail to update/load systematically must be manually updated within twenty-four (24) hours of receipt. The CONTRACTOR shall report to TENNCARE, in a form and format to be provided by TENNCARE, outbound 834 transactions that are not processed within these time frames and include information regarding when the transactions were completed. Any transactions that are not updated/loaded within twenty-four (24) hours of receipt from TENNCARE and/or persistent issues with high volumes of transitions that require manual upload may require the CONTRACTOR to initiate a Corrective Action Plan for resolution of the issues preventing compliance.

65. Section 2.25.9.1 shall be amended by deleting and replacing the words "disease management" with "Population Health".

66. Section 2.26.9 shall be amended by adding the words "and providers" as follows:

2.26.9 Interpretation/Translation Services and Limited English Proficiency (LEP) Provisions

The CONTRACTOR shall provide instruction for all direct service subcontractors and providers regarding the CONTRACTOR's written procedure for the provision of language interpretation and translation services for any member who needs such services, including but not limited to, enrollees with Limited English Proficiency.



Amendment 30 (cont.)

67. Section 2.28.6 shall be deleted in its entirety and the remaining Section shall be renumbered accordingly, including any references thereto.

68. The renumbered Sections 2.28.6 and 2.28.7 shall be deleted and replaced as follows:

2.28.6 All discrimination complaints against the CONTRACTOR, CONTRACTOR's employees, CONTRACTOR's providers, CONTRACTOR's provider's employees and CONTRACTOR's subcontractors shall be resolved according to the provisions of this Section 2.28.6.

2.28.6.1 Discrimination Complaints against the CONTRACTOR and/or CONTRACTOR's Employees. When complaints concerning alleged acts of discrimination committed by the CONTRACTOR and/or its employees related to the provision of and/or access to TennCare covered services are reported to the CONTRACTOR, the CONTRACTOR's nondiscrimination compliance officer shall send such complaints within two (2) business days of receipt to TENNCARE. TENNCARE shall investigate and resolve all alleged acts of discrimination committed by the CONTRACTOR and/or its employees. The CONTRACTOR shall assist TENNCARE during the investigation and resolution of such complaints. TENNCARE reserves the right to request that the CONTRACTOR's nondiscrimination compliance officer assist with conducting the initial investigations and to suggest resolutions of alleged discrimination complaints. If a request for assistance with an initial investigation is made by TENNCARE, the CONTRACTOR's nondiscrimination compliance officer shall provide TENNCARE with all requested information, including but not limited to, the identity of the party filing the complaint; the complainant's relationship to the CONTRACTOR; the circumstances of the complaint; date complaint filed; and the CONTRACTOR's suggested resolution. TENNCARE shall review the CONTRACTOR's initial investigations and determine the appropriate resolutions for the complaints as set forth in Section 2.28.6.3 below. Any documentation or materials related to such investigation shall be considered confidential and not subject to disclosure to any third party, unless disclosure is otherwise required by law.

2.28.6.2 Discrimination Complaints against the CONTRACTOR's Providers, Provider's Employees and/or Provider's Subcontractors. Should complaints concerning alleged acts of discrimination committed by the CONTRACTOR's providers, provider's employees and/or subcontractors related to the provision of and/or access to TennCare covered services be reported to the CONTRACTOR, the CONTRACTOR's nondiscrimination compliance officer shall inform TENNCARE of such complaints within two (2) business days from the date CONTRACTOR learns of such complaints. The CONTRACTOR's nondiscrimination compliance officer shall, within five (5) business days of receipt of such complaints, begin to document and conduct the initial investigations of the complaints. Once an initial investigation has been completed, the CONTRACTOR's nondiscrimination compliance officer shall report his/her determinations to TENNCARE. At a minimum, the CONTRACTOR's nondiscrimination compliance officer's report shall include the identity of the party filing the complaint; the complainant's relationship to the CONTRACTOR; the circumstances of the complaint; date complaint filed; and the CONTRACTOR's suggested resolution. TENNCARE shall review the CONTRACTOR's initial investigations and determine the appropriate resolutions for the complaints as set forth in Section 2.28.6.3 below. TENNCARE reserves the right to investigate and resolve all complaints concerning alleged acts of discrimination committed by the CONTRACTOR's providers, and subcontractors.



Amendment 30 (cont.)

2.28.6.3 Corrective Action Plans to Resolve Discrimination Complaints. If a discrimination complaint against the CONTRACTOR, CONTRACTOR's employees, CONTRACTOR's providers, CONTRACTOR's provider's employees, or CONTRACTOR's subcontractors is determined by TENNCARE to be valid, TENNCARE shall, at its option and pursuant to Section 2.25.10, either (i) provide the CONTRACTOR with a corrective action plan to resolve the complaint, or (ii) request that the CONTRACTOR submit a proposed corrective action plan to TENNCARE for review and approval that specifies what actions the CONTRACTOR proposes to take to resolve the discrimination complaint. Upon provision of the corrective action plan to CONTRACTOR by TENNCARE, or approval of the CONTRACTOR's proposed corrective action plan by TENNCARE, the CONTRACTOR shall implement the approved corrective action plan to resolve the discrimination complaint. TENNCARE, in its sole discretion, shall determine when a satisfactory discrimination complaint resolution has been reached and shall notify CONTRACTOR of the approved resolution. A discrimination complaint resolution corrective action plan may consist of approved nondiscrimination training on relevant discrimination topics. Prior to use, the nondiscrimination training material shall be reviewed and approved by TENNCARE. Time periods for the implementation of the corrective action plan nondiscrimination training shall be designated by TENNCARE.

2.28.7 The CONTRACTOR shall use and have available to TennCare enrollees, TennCare's Discrimination complaint form located on TennCare's website under the nondiscrimination link at <http://www.tn.gov/tenncare/members.shtml>. The discrimination complaint form shall be provided to TennCare enrollees upon request and in the member handbook. This complaint form shall be available in English and Spanish. When requests for assistance to file a discrimination complaint are made by enrollees, the CONTRACTOR shall assist the enrollees with submitting complaints to TENNCARE. In addition, the CONTRACTOR shall inform its employees, providers, and subcontractors how to assist TENNCARE enrollees with obtaining discrimination complaint forms and assistance from the CONTRACTOR with submitting the forms to TENNCARE and the CONTRACTOR.

69. Section 2.29.1.3.19 shall be deleted and replaced as follows:

2.29.1.3.19 A staff person responsible for all Population Health and related issues, including but not limited to, Population Health activities and coordination between physical and behavioral health services;

70. Section 2.29.1.4 shall be deleted and replaced as follows:

2.29.1.4 In addition to the key staff requirements described above, the CONTRACTOR shall have sufficient full-time clinical and support staff to conduct daily business in an orderly manner. This includes but is not limited to functions and services in the following areas: administration, accounting and finance, fraud and abuse, utilization management including prior authorizations, Population Health, care coordination, QM/QI, member education and outreach, appeal system resolution, member services, provider services, provider relations, claims processing, and reporting.

71. Section 2.29.1.9 shall be deleted and replaced as follows:

2.29.1.9 The CONTRACTOR's project director, transition staff person, Medical Director, psychiatrist, CHOICES senior executive, financial staff, member services staff, provider services staff, provider relations staff, CHOICES provider claims education and assistance staff, UM staff,



Amendment 30 (cont.)

appeals staff, Population Health Complex Case Management staff care coordination staff, consumer advocate, and TENNderCare staff person shall be located in the State of Tennessee. However, TENNCARE may authorize exceptions to this requirement. The CONTRACTOR shall seek TENNCARE's written prior approval to locate any of these staff outside of the State of Tennessee. The CONTRACTOR's request to locate required in-state staff to an out-of-state location shall include a justification of the request and an explanation of how services will be coordinated. If financial staff are not located in Tennessee the CONTRACTOR shall have the ability to issue a check within five (5) calendar days of a payment directive from TENNCARE.

72. Section 2.30.5 and 2.30.5.1 shall be deleted and replaced as follows:

2.30.5 Disease Management/Population Health Reports

2.30.5.1 The CONTRACTOR shall submit a quarterly *Population Health Update Report* addressing all seven (7) Population Health Programs (see Section 2.8.4 of this Agreement). The report shall include process and operational data and any pertinent narrative to include any staffing changes, training or new initiatives occurring in the reporting period.

73. Section 2.30.5.3 shall be deleted and replaced as follows:

2.30.5.3 The CONTRACTOR shall submit on March 30, 2013, a *Population Health Program Description* following the guidance provided by TENNCARE addressing Section 2.8 of this Agreement. The program description shall include a written description of how the plan assures that members less than 21 years of age will have their health risks identified and their health needs met at the appropriate risk Level. The program description shall also include a CHOICES narrative as outlined in Section 2.8.11 of this Agreement and address the Clinical Practice Guidelines reference in Section 2.8.6 of this Agreement.

74. Section 2.30.6.1 through 2.30.6.1.3 shall be deleted and replaced as follows:

2.30.6.1 MCO Case Management Reports

2.30.6.1.1 The CONTRACTOR shall submit an annual *MCO Case Management Services Report* that addresses the activities in Section 2.9.5 of the prior Agreement by July 1 of 2013.

75. Section 2.30.7.2.1 and 2.30.7.2.2 shall be deleted and replaced as follows:

2.30.7.2.1 the number and percent of SelectCommunity members for whom the CONTRACTOR has/has not reassessed the member's physical and behavioral health needs at least annually (defined as within 365 days of the member's enrollment date pursuant to section 3A.7.3); and

2.30.7.2.2 the number and percent of SelectCommunity members for whom the CONTRACTOR has/has not reassessed the member's physical and behavior health needs within 10 days of becoming aware that the member's functional, physical, or behavioral status has changed significantly as defined by but not limited to section 3.A.8.1.1 thru 3.A.8.1.5.



Amendment 30 (cont.)

76. Section 2.30.8.1 shall be deleted and replaced as follows:

2.30.8.1 The CONTRACTOR shall submit a monthly *Provider Enrollment File* that includes information on all providers of TennCare health services, including physical, behavioral health, and long-term care providers (see Section 2.11). This includes but is not limited to, PCPs, physician specialists, hospitals, home health agencies, CMHAs, nursing facilities, CHOICES HCBS providers, and emergency and non-emergency transportation providers. For CHOICES HCBS providers, the *Provider Enrollment File* shall identify the type(s) of CHOICES HCBS the provider is contracted to provide and the specific counties in which the provider is contracted to deliver CHOICES HCBS, by service type. The report shall include contract providers as well as all non-contract providers with whom the CONTRACTOR has a relationship. During any period of readiness review, the CONTRACTOR shall submit this report as requested by TENNCARE. Each monthly *Provider Enrollment File* shall include information on all providers of covered services and shall provide a complete replacement for any previous *Provider Enrollment File* submission. Any changes in a provider's contract status from the previous submission shall be indicated in the file generated in the month the change became effective and shall be submitted in the next monthly file.

77. Section 2.30.8.7 shall be deleted and replaced as follows:

2.30.8.7 The CONTRACTOR shall submit an annual *CHOICES Qualified Workforce Strategies Report* that describes any additional strategies the CONTRACTOR elects to undertake to assist in the development of an adequate qualified workforce for covered long-term care services, increase the available qualified direct care staff, and improve the retention of qualified direct care staff (see Section 2.11.6.7). At a minimum, the report shall include a brief description of each of any additional strategies the CONTRACTOR elects to undertake; activities associated with each of the CONTRACTOR's strategies, including associated partnerships; timeframes for implementing each strategy and associated activities; the status of each strategy and associated activities; and a brief summary of the current and anticipated impact of each strategy and associated activities. Should the CONTRACTOR elect not to pursue additional activities (beyond the statewide initiative), this report shall be submitted timely and shall report that the CONTRACTOR has elected not to pursue additional activities beyond the statewide initiative.

78. Section 2.30.12.6 shall be deleted and replaced by new Sections 2.30.12.6 and 7 and the remaining Sections of 2.30.12 shall be renumbered accordingly, including any references thereto.

2.30.12.6 The CONTRACTOR shall submit an annual *Report of Audited HEDIS Results* by June 15 of each year (see Sections 2.15.6).

2.30.12.7 The CONTRACTOR shall submit an annual *Report of Audited CAHPS Results* by June 15 of each year (see Sections 2.15.6).

79. The existing Section 2.30.12.9 shall be deleted in its entirety including any references thereto.



Amendment 30 (cont.)

80. Section 2.30.13.3 shall be deleted in its entirety and the renumbered Section 2.30.13.3 shall be deleted and replaced by new Sections 2.30.13.3 and 4 as follows:

2.30.13.3 The CONTRACTOR shall submit an annual *Provider Satisfaction Survey Report* that encompasses behavioral and physical health. The report shall summarize the provider survey methods and findings and must provide an analysis of opportunities for improvement (see Section 2.18.7.4) The report shall be submitted by July 1 each year.

2.30.13.4 The CONTRACTOR shall submit an annual *CHOICES Provider Satisfaction Survey Report* that addresses results for CHOICES long-term care providers. The report shall summarize the provider survey methods and findings, must provide an analysis of opportunities for improvement (see Section 2.18.7.5) in addition to CHOICES items specified in the protocols provided by TENNCARE. The report shall be submitted by July 1 each year.

81. Section 2.30.16.2.1 shall be amended by deleting the reference to Section “2.30.17.3” and replacing it with the reference to “2.30.18.3”.

82. Section 2.30.18 shall be amended by adding a new Section 2.30.18.4 as follows and renumbering the remaining Section accordingly, including any references thereto.

2.30.18.4 The CONTRACTOR shall submit a quarterly *Encounter/MLR Reconciliation Report* and a *Companion Data File* to demonstrate the reconciliations between the submissions of encounter files and MLR Claim Triangle reports.

2.30.18.4.1 The companion data file shall be in an Excel format and shall represent a claim triangle report in terms of claim counts and total payment based on all encounter batch files submitted to TennCare EDI during the prior quarter with delineations by ‘paid month’, ‘incurred month’, ‘claim types (as it is defined in the MLR Triangle report)’, and ‘encounter batch file ID’.

2.30.18.4.2 The reconciliation report shall include an overall assessment of reporting integrities between the two Claim Triangle reports in terms of counts and amount based on the common delineations. When the two reports are not reconciling under the common delineations, the CONTRACTOR shall address the root causes of the gaps with proposed corrective action plans.

83. Section 2.30.22.2 shall be deleted in its entirety and the remaining Section shall be renumbered accordingly, including any references thereto.

84. The renumbered Section 2.30.22.2 shall be deleted and replaced as follows:

2.30.22.2 Annually, TENNCARE shall provide the CONTRACTOR with a Nondiscrimination Compliance Plan Template. The CONTRACTOR shall answer the questions contained in the Compliance Plan Template and submit the completed *Compliance Plan* to TENNCARE within ninety (90) days of the end of the calendar year with any requested documentation, which shall include, but is not limited to, the Assurance of Nondiscrimination. The signature date of the CONTRACTOR’s Nondiscrimination Compliance Plan shall be the same as the signature date of the CONTRACTOR’s Assurance of Nondiscrimination. These deliverables shall be in a format specified by TENNCARE.



Amendment 30 (cont.)

85. The renumbered Section 2.30.22.3.2 shall be deleted and replaced as follows:

2.30.22.3.2 A listing of all complaints filed by employees, members, providers and subcontractors in which discrimination is alleged related to the provision of and/or access to TennCare covered services provided by the CONTRACTOR. Such listing shall include, at a minimum: identity of the complainant, complainant's relationship to the CONTRACTOR, circumstances of the complaint, type of covered service related to the complaint, date complaint filed, the CONTRACTOR's resolution, date of resolution, and the name of the CONTRACTOR staff person responsible for adjudication of the complaint. For each complaint reported as resolved the CONTRACTOR shall submit a copy of the complainant's letter of resolution.

86. Section 3A.1.1.4 and 3A.1.1.5 shall be deleted and replaced as follows:

3A.1.1.4 Ongoing coordination with long-term care services the member receives, including Home and Community Based Services (HCBS) provided under a Section 1915(c) waiver program for persons with intellectual disabilities (i.e., mental retardation) or Institutional services in an Intermediate Care Facility for persons with Mental Retardation (ICF/IID) or Nursing Facility (NF), as applicable; and

3A.1.1.5 Continuous collaboration between the member's care providers and payors, including TennCare, the Tennessee Department of Finance & Administration - Department of Intellectual and Developmental Disabilities (DIDD, formerly known as DIDS), and the CONTRACTOR who will be responsible for the coordination, delivery and payment of all medically necessary covered physical and behavioral health services.

87. Section 3A.1.3 shall be amended by deleting the reference to "ICF/MR" and replacing it with the reference to "ICF/IID".

88. Section 3A.2.1 shall be deleted and replaced as follows:

3A.2.1 The Target Population for the Integrated Health Services Delivery Model shall include only the following:

3A.2.1.1. Members of the Arlington Class regardless of service delivery setting;

3A.2.1.2. Persons actively enrolled in one of the State's Section 1915(c) waivers for persons with Intellectual Disabilities.

89. The first sentence of Section 3A.2.2 shall be amended by deleting the word "also" and by adding "/IID" after "ICFs".



Amendment 30 (cont.)

90. Section 3A.2 shall be amended by deleting and replacing Section 3A.2.5 as follows and adding a new Section 3A.2.6 from the language deleted in the next Section 3A.3.

3A.2.5 For members of the target population, TENNCARE will notify the CONTRACTOR via the 834 outbound eligibility file when the member has been enrolled in TennCare Select because s/he is in the defined target population and has elected to opt into TennCare Select. Only members assigned to TennCare Select by TennCare (i.e., based on exercise of an opt-in opportunity or an MCO change request) may participate in the Integrated Health Services Delivery Model.

3A.2.6 All members of the target population assigned to TennCare Select that elect to participate shall be assigned to the Integrated Health Services Delivery Model.

91. Section 3A.3 shall be deleted in its entirety and the remaining Section 3A shall be renumbered accordingly, including any references thereto.

92. The renumbered Section 3A.3.1.6 shall be amended by deleting and replacing the reference from “DIDS” to “DIDD”.

93. The renumbered Section 3A.3.3 shall be deleted and replaced as follows:

3A.3.3 The CONTRACTOR shall ensure that, upon enrollment into the Integrated Health Services Delivery Model, Population Health activities for the target population are integrated with Nurse Care Management processes and functions, and that the member’s assigned Nurse Care Manager has primary responsibility for coordination of all the member’s physical and behavioral health needs. The Nurse Care Manager may use resources and staff from the CONTRACTOR’s appropriate Population Health Program, including persons with specialized expertise in areas such as behavioral health, to supplement but not supplant the role and responsibilities of the Nurse Care Manager.

94. The renumbered Section 3A.4 shall be amended by deleting and replacing the heading of 3A.4 and deleting and replacing Section 3A.4.1 as follows:

3A.4 Assignment of a Nurse Care Manager to Members

3A.4.1 The CONTRACTOR shall, within five (5) business days after notification of enrollment of each new member in the target population assign a specific Nurse Care Manager who shall have primary responsibility for performance of Nurse Care Management activities as specified in this Section, and who shall be the member’s point of contact for coordination of physical and behavioral health services.

95. The renumbered Section 3A.5.1.1 shall be deleted and replaced as follows:

3A.5.1.1 For participants who opt into the Integrated Health Services Delivery Model, such face-to-face assessment shall be as soon as possible after enrollment into TennCare Select, but must be completed in time to ensure the development of an individualized, Integrated Plan of Health Care within the timeframes set forth below

96. The renumbered Section 3A.5.2 shall be amended by deleting the phrase “DIDS and/or by CSN” and replacing it with the word “DIDD”.



Amendment 30 (cont.)

97. The renumbered 3A.6.1 shall be amended by adding a new Section 3A.6.1.1 which shall read as follows:

3A.6.1.1 The Integrated Plan of Health Care, which focuses on the member’s physical and behavioral health needs, shall not replace the Individualized Support Plan (ISP) which is developed by the Independent Supports Coordinator with the enrollee and the enrollee’s representative and Circle of Support and which identifies the HCBS Waiver benefits that are needed by the member.

98. The renumbered Section 3A.6.2 and 3A.6.3 shall be deleted and replaced as follows:

3A.6.2 The Care Management Support Team shall be led by the Nurse Care Manager and shall include the member and his/her family, guardian or conservator (as applicable). The Team may also include (as appropriate), but is not limited to the member’s Primary Care Physician, Independent Support Coordinator (ISC) or Waiver Case Manager (WCM), as applicable, ID Waiver providers, DIDD Advocate, physical and/or behavioral health care providers, and other VSHP staff such as the physical or behavioral health Medical Director(s), Social Worker, etc .

3A.6.3 For Arlington class members residing in Institutional Placements, the Integrated Plan of Health Care shall supplement the facility’s plan of care (which is required pursuant to federal regulation), and shall focus on the provision of services covered by TennCare Select that are beyond the scope of the Institutional ICF/IID or NF benefit, including targeted strategies related to improving health, functional, or quality of life outcomes (e.g., related to disease management or pharmacy management) or to increasing and/or maintaining health and/or functional status, as appropriate.

99. The renumbered Section 3A.6.6 shall be amended by deleting and replacing the words “disease management” with the words “Population Health”.

100. The renumbered Section 3A.7 shall be amended by adding new Section 3A.7.3 through 3A.7.3.2 as follows:

3A.7.3 The annual reassessment date shall be calculated from the effective date of enrollment into the Integrated Health Services Delivery Model.

3A.7.3.1 For members who disenroll from and re-enroll into the Integrated Health Services Delivery Model within thirty (30) or less days, the annual reassessment shall be based on the initial effective date of enrollment.

3A.7.3.2 For members who disenroll from and re-enroll into the Integrated Health Services Delivery Model after thirty-one (31) or more days, the member shall be assessed as a new enrollee and the annual reassessment date shall be the based on the effective date of the re-enrollment.

101. The renumbered Section 3A.11.2 shall be amended by deleting and replacing the words “disease management” with the words “Population Health”.

102. The renumbered Section 3A.13.1.1 shall be deleted in its entirety as well as any references thereto.



Amendment 30 (cont.)

103. The renumbered Section 3A.13.4 shall be deleted and replaced as follows:

3A.13.4 The CONTRACTOR shall use information regarding members gathered through assessment UM, and other processes as well as predictive modeling to help identify members with the most significant health and/or behavioral health needs who are at the highest risk and who offer the greatest potential for improvements in health outcomes, and to stratify members and prioritize Nurse Care Manager resources accordingly, such that individual Nurse Care Managers may have a greater or lesser number of assigned members based on the level of need of such members. For a period of two (2) years following implementation of the Integrated Health Services Delivery Model, the average Nurse Care Manager-to-member ratio shall not exceed 1:35 for Arlington class members who are not in an ICF/IID or other institutional placement.

104. The renumbered Section 3A.14.1.16 shall be amended by deleting and replacing the words “Disease management” with the words “Population Health”.

105. The renumbered Section 3A.17.1.3 shall be deleted and replaced as follows:

3A.17.1.3 The ability to track and notify the Nurse Care Manager regarding key dates, e.g., date for minimum Nurse Care Manager contacts; date for annual reassessment of needs; including, for the purposes of reassessments, the ability to track and calculate when a member disenrolls from the Integrated Health Services model and re-enrolls within thirty (30) or less days.

106. The existing Section 3A.19 shall be deleted in its entirety.

107. The renumbered Section 3A.18.1 and 3A.18.4 shall be amended by deleting and replacing references to “ICF/MR” with “ICF/IID” and “DIDS” with “DIDD”.

108. The renumbered Section 3A.19 shall be amended by deleting Section 3A.19.6 in its entirety and the remaining Section shall be renumbered accordingly, including any references thereto.

109. Section 4.8.1 shall be deleted and replaced as follows:

4.8.1 In no event shall the maximum liability of the State under this Agreement during the original term of the Contract exceed three billion, one hundred sixty two million, seven hundred ten thousand, three hundred five dollars and ninety cents (\$3,162,710,305.90).



Amendment 30 (cont.)

110. Section 5.2.1 shall be amended by deleting and replacing “June 30, 2013” with December 31, 2014” as follows:

5.2.1 This Agreement, and its incorporated attachments, if any, as well as all Amendments to this Agreement, contain all of the terms and conditions agreed upon by the parties, and when executed by all parties, supersedes any prior agreements. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall be in effect from July 1, 2001, subject to approval by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The term of this Agreement shall expire on December 31, 2014. At the mutual agreement of TENNCARE and the CONTRACTOR, this Agreement shall be renewable for an additional twelve month period.

111. Section 5.20.2.2.7 shall be amended by adding a new Level A.32 Program Issue/Damage as follows:

A.32	Failure to ensure that a level of care (i.e., PAE) and supporting documentation submitted with the level of care is accurate and complete, satisfies all technical requirements specified by TENNCARE, and accurately reflects the member’s current medical and functional status. (see Section 2.9.6.3.14.)	<p>\$2,000 per occurrence</p> <p>These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing recommendations as specified in Section 2.9.6.11.9 of this Agreement</p>
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112. Section 5.20.2.2.7 shall be amended by deleting and replacing the Program Issues/Damage of Level B.2, adding additional language to the Damage Section of B.23, and adding a new Level B.27 as follows:

B.2	Failure to provide a timely and acceptable corrective action plan or comply with corrective action plans as required by TENNCARE	<p>\$500 per calendar day for each day the corrective action plan is late, or for each day the CONTRACTOR fails to comply with an accepted corrective action as required by TENNCARE</p> <p>\$2000 for failure to provide an acceptable initial corrective action plan as determined by TENNCARE in addition to \$500 per calendar day from the date of notice of deficiency by TENNCARE for each day the corrective action plan remains deficient</p> <p>If subsequent corrective action plans are deficient, the \$500 per calendar day shall continue until an acceptable plan as determined by TENNCARE is received</p>
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Amendment 30 (cont.)

<p>B.23</p>	<p>Failure to meet any timeframe regarding care coordination for CHOICES members (see Sections 2.9.2, 2.9.3, and 2.9.6) other than the timeframes referenced in A.16 or A.17</p>	<p>\$5,000 per month for each timeframe that the CONTRACTOR's performance is 85-89% \$10,000 per month for each timeframe that the CONTRACTOR's performance is 80-84% \$20,000 per month for each timeframe that the CONTRACTOR's performance is 75-79% \$50,000 per month for each timeframe that the CONTRACTOR's performance is 70-74% \$100,000 per month for each timeframe that the CONTRACTOR's performance is 69% or less</p> <p>These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing recommendations as specified in Section 2.9.6.11.9 of this Agreement.</p> <p>In instances where the denominator is less than two hundred (200), TENNCARE may opt, at its discretion, to apply a \$500 per occurrence assessment in lieu of the methodology described above. This per occurrence amount shall be multiplied by two (2), totaling a \$1,000 per occurrence assessment when the CONTRACTOR has not complied with the Caseload and Staffing recommendations as specified in Section 2.9.6.11.9 of this Agreement.</p>
<p>B.27</p>	<p>Failure to meet individual Annual Quality Survey standards in subsequent years</p>	<p>\$5000 per occurrence for repeating a deficiency(ies) in subsequent years</p>

113. Attachments III and IV shall be amended by adding the following language to the end of the existing text:

TENNCARE will evaluate the need for further action when the above standards are not met. At its sole discretion TENNCARE may elect one of three options: (1) TENNCARE may request a Corrective Action Plan (CAP), (2) a Request for Information (RFI), (3) or an On Request Report (ORR) depending on the severity of the deficiency.

The requested CAP, RFI or ORR response shall detail the CONTRACTOR's network adequacy considering any alternate measures, documentation of unique market conditions and/or its plan for correction. If TENNCARE determines the CONTRACTOR's response demonstrates existence of alternate measures or unique market conditions, TENNCARE may elect to request periodic updates from the CONTRACTOR regarding efforts to address such conditions.



114. Attachment V shall be deleted and replaced in its entirety as follows:

ATTACHMENT V

ACCESS & AVAILABILITY FOR BEHAVIORAL HEALTH SERVICES

The CONTRACTOR shall adhere to the following behavioral health network requirements to ensure access and availability to behavioral health services for all members (adults and children). For the purpose of assessing behavioral health provider network adequacy, TENNCARE will evaluate the CONTRACTOR’s provider network relative to the requirements described below. Providers serving adults will be evaluated separately from those serving children.

Access to Behavioral Health Services

The CONTRACTOR shall ensure access to behavioral health providers for the provision of covered services. At a minimum, this means that:

The CONTRACTOR shall have provider agreements with providers of the services listed in the table below and meet the geographic and time for admission/appointment requirements.

Service Type	Geographic Access Requirement	Maximum Time for Admission/ Appointment
Psychiatric Inpatient Hospital Services	Travel distance does not exceed 60 miles for at least 75% of members and does not exceed 90 miles for at least 90% of members	4 hours (emergency involuntary)/24 hours (involuntary)/24 hours (voluntary)
24 Hour Psychiatric Residential Treatment	The CONTRACTOR shall contract with at least one (1) provider of service in the Grand Region for ADULT members ----- Travel distance does not exceed 60 miles for at least 75% of CHILD members and does not exceed 90 miles for at least 90% of CHILD members	Within 30 calendar days
Outpatient Non-MD Services	Travel distance does not exceed 30 miles for ALL members	Within 10 business days; if urgent, within 48 hours
Intensive Outpatient (may include Day Treatment (adult), Intensive Day Treatment (Children & Adolescent) or Partial Hospitalization)	Travel distance does not exceed 90 miles for at least 90% of members	Within 10 business days; if urgent, within 48 hours



Amendment 30 (cont.)

Inpatient Facility Services (Substance Abuse)	Travel distance does not exceed 90 miles for at least 90% of members	Within 2 calendar days; for detoxification - within 4 hours in an emergency and 24 hours for non-emergency
24 Hour Residential Treatment Services (Substance Abuse)	The CONTRACTOR shall contract with at least one (1) provider of service in the Grand Region for ADULT members ----- The CONTRACTOR shall contract with at least one (1) provider of service in the Grand Region for CHILD members	Within 10 business days
Outpatient Treatment Services (Substance Abuse)	Travel distance does not exceed 30 miles for ALL members	Within 10 business days; for detoxification – within 24 hours
Mental Health Case Management	Not subject to geographic access standards	Within 7 calendar days
Psychosocial Rehabilitation (may include Supported Employment, Illness Management & Recovery, or Peer Support)	Not subject to geographic access standards	Within 10 business days
Supported Housing	Not subject to geographic access standards	Within 30 calendar days
Crisis Services (Mobile)	Not subject to geographic access standards	Face-to-face contact within 1 hour for emergency situations and 4 hours for urgent situations
Crisis Stabilization	Not subject to geographic access standards	Within 4 hours of referral

TENNCARE will evaluate the need for further action when the above standards are not met. At its sole discretion TENNCARE may elect one of three options: (1) TENNCARE may request a Corrective Action Plan (CAP), (2) a Request for Information (RFI), (3) or an On Request Report (ORR) depending on the severity of the deficiency.

The requested CAP, RFI or ORR response shall detail the CONTRACTOR’s network adequacy considering any alternate measures, documentation of unique market conditions and/or its plan for correction. If TENNCARE determines the CONTRACTOR’s response demonstrates the existence of alternate measures or unique market conditions, TENNCARE may elect to request periodic updates from the CONTRACTOR regarding efforts to address such conditions.



Amendment 30 (cont.)

At a minimum, providers for the following service types shall be reported on the Provider Enrollment File:

Service Type	Service Code(s) for use in position 330-331 of the Provider Enrollment File
Psychiatric Inpatient Hospital Services	Adult - 11, 79, 85 Child - A1 or H9
24 Hour Psychiatric Residential Treatment	Adult - 13, 81, 82 Child - A9, H1, or H2
Outpatient MD Services (Psychiatry)	Adult - 19 Child - B5
Outpatient Non-MD Services	Adult - 20 Child - B6
Intensive Outpatient/ Partial Hospitalization	Adult - 21, 23, 62 Child - B7, C2, C3
Inpatient Facility Services (Substance Abuse)	Adult - 15, 17 Child - A3, A5
24 Hour Residential Treatment Services (Substance Abuse)	Adult - 56 Child - F6
Outpatient Treatment Services (Substance Abuse)	Adult - 27 or 28 Child - D3 or D4
Mental Health Case Management	Adult - 31, 66, or 83 Child - C7, D7, G2, G6, or K1
Psychiatric Rehabilitation Services:	
Psychosocial Rehabilitation	42
Supported Employment	44
Peer Support	88
Illness Management & Recovery	91
Supported Housing	32 and 33
Crisis Services (Mobile)	Adult - 37, 38, 39 Child - D8, D9, E1
Crisis Respite	Adult - 40 Child - E2
Crisis Stabilization	Adult 41



Amendment 30 (cont.)

- 115. Attachment VI shall be amended by adding a “MCE TIP SUBMISSION FORM” as described below in front of the existing “POTENTIAL FRAUD ALLEGATION REFERRAL FORM” and “REPORT TENNCARE RECIPIENT FRAUD OR ABUSE” forms.

MCE TIP SUBMISSION FORM

related to

POTENTIAL PROVIDER FRAUD and PATIENT SAFETY

(template with sample data)

DATE: Month/Day/Year

TO: TBI, Medicaid Fraud Control Unit (MFCU)
TennCare, Office of Program Integrity

FROM: Your MCE Name

Contact Person: 1st & Last name; Telephone; EMail;

SOURCE OF TIP(s):
HOTLINE

INFORMATION OF TIP(s):
ABC Clinic, John Smith MD, Family Practice

Description of allegation of wrong doing: (example: Dr Smith is being reviewed for upcoding E&M)

MCE CONTRACT PERSON ON THE TIP(s):
JOHN DOW

TennCare Recommended MCC TIP/Referral Protocol:

- 1) The submission of documents related to the provider fraud and abuse referral should be via TennCare SFTP server (**path: tncare.sftp.state.tn.us/tncare/MCC###/orr/OPI/in**) with password protections on Documents;
- 2) Concurrently, a notice of submission should be e-mailed to ProgramIntegrity.TennCare@tn.gov with a subject line stating "MCC### Notice of Referral Submission via SFTP" along with password notices on opening documents.



Amendment 30 (cont.)

116. Section A.1 of Attachment XI shall be amended by adding a new Section A.1.3 as follows:

A.1.3 The CONTRACTOR shall develop and submit to the Bureau of TennCare for approval, a policy addressing No-Shows which limits the amount of trips a member can take when the CONTRACTOR has determined that the member has missed scheduled trips for NEMT services for a designated number of trips. Upon the approval of these policies by the Office of Contract Compliance, the CONTRACTOR shall assure all policies are implemented and followed by their NEMT brokers and their providers.

117. Section A.3.1 of Attachment XI shall be amended by adding additional language to the end of the existing text as follows:

A.3.1 Members or their representatives shall be allowed to make requests for NEMT services on behalf of members. For DCS enrollees (as defined in Exhibit A of this Attachment), representatives include the member's DCS liaison, foster parent, adoptive parent, or provider. For members enrolled in an HCBS waiver for persons with Intellectual Disabilities, the member's Independent Support Coordinator/Case Manager or the member's residential or day services provider may make requests for NEMT services, even when the member's residential or day services provider is also a the contract provider that will deliver the NEMT services to the member.

118. Section A.4.2 of Attachment XI shall be deleted and replaced as follows:

A.4.2 Verifying Eligibility for NEMT Services

A.4.2.1 The CONTRACTOR shall screen all requests for NEMT services to confirm each of the following items:

A.4.2.2 That the person for whom the transportation is being requested is a TennCare enrollee and enrolled in the CONTRACTOR's MCO;

A.4.2.3 That the service for which NEMT service is requested is a TennCare covered service (as defined in Exhibit A of this Attachment);

A.4.2.4 That the enrollee is eligible in accordance with policies and procedures approved by the Office of Contract Compliance regarding No-Shows; and

A.4.2.5 That the transportation is a covered NEMT service (see Section 2.6.1.3 of the Agreement).

119. Section A.4.6 of Attachment XI shall be deleted and replaced as follows:

A.4.6 Validating Requests

A.4.6.1 The CONTRACTOR shall conduct random pre-transportation validation checks prior to approving the request in order to prevent fraud and abuse. The amount validated shall be two percent (2%) of NEMT scheduled trips per month.

A.4.6.2 The CONTRACTOR may verify the need for an urgent trip with the provider prior to approving the trip.

A.4.6.3 If requested by TENNCARE, the CONTRACTOR shall conduct pre-transportation validation checks of trips requested by specified members and/or to specific services or providers.



Amendment 30 (cont.)

A.4.6.4 Focus of the Pre-Validations shall be, but may not be limited to, members who utilize NEMT services frequently but do not have standing orders as well as members who routinely do not adhere to the seventy-two (72) hour notice requirement.

A.4.6.5 All pre-transportation validation checks shall be conducted within the timeframes specified in Section A.5.1.4 of this Attachment.

120. Section A.5.1 of Attachment XI shall be amended by adding a new Section A.5.1.2 as follows and renumbering the remaining Section accordingly, including any references thereto.

A.5.1.2 After approving a NEMT service to be provided by a NEMT provider (i.e., not fixed route), the CONTRACTOR shall schedule and assign the trip to an appropriate NEMT provider (see A.5.3 for persons enrolled in an HCBS waiver for persons with Intellectual Disabilities).

121. Section A.5.3 of Attachment XI shall be deleted and replaced as follows:

A.5.3 Choice of NEMT Provider

Except for persons enrolled in an HCBS waiver for persons with Intellectual Disabilities, the CONTRACTOR is not required to use a particular NEMT provider or driver requested by the member. However, the CONTRACTOR may accommodate a member's request to have or not have a specific NEMT provider or driver. If an HCBS waiver participant's residential or day services waiver provider is enrolled with the CONTRACTOR as an NEMT provider (pursuant to A.12.5), the CONTRACTOR shall permit the residential or day services waiver provider to provide medically necessary, covered NEMT services for waiver participants receiving HCBD ID waiver services from the provider, so long as the provider is able to provide the appropriate mode and level of service in a timely manner.

122. Section A.5.4 of Attachment XI shall be deleted and replaced as follows:

A.5.4 Notifying Members of Arrangements

If possible, the CONTRACTOR shall inform the member of the transportation arrangements (see below) during the phone call requesting the NEMT service. Otherwise, the CONTRACTOR shall obtain the member's preferred method (e.g., phone call, email, fax) and time of contact, and the CONTRACTOR shall notify the member of the transportation arrangements (see below) as soon as the arrangements are in place (within the timeframe specified in Section A.5.1.4 of this Attachment) and prior to the date of the NEMT service. Responsibility of determining whether transportation arrangements have been made shall not be delegated to the member. Information about transportation arrangements shall include but not be limited to the name and telephone number of the NEMT provider, the scheduled time and address of pick-up, and the name and address of the provider to whom the member seeks transport.

123. Section A.5.5.1 of Attachment XI shall be amended by adding a new sentence to the end of the existing language as follows:

A.5.5.1 The CONTRACTOR shall provide a trip manifest to the NEMT provider of all new trips requested prior to 5 p.m. on the same business day.



Amendment 30 (cont.)

- 124. Section A.5.5.4 of Attachment XI shall be amended by deleting the word “or” and replacing it with the word “and” as follows:**

A.5.5.4 If the CONTRACTOR notifies a NEMT provider of a trip assignment after the timeframe specified in Section A.5.5.1, the CONTRACTOR shall also contact the NEMT provider by telephone and electronically to confirm that the trip will be accepted.

- 125. Section A.5.7 of Attachment XI shall be amended by adding a new second sentence in the middle of existing language as follows:**

A.5.7 Urgent Trips

For urgent trips (as defined in Exhibit A of this Attachment), the CONTRACTOR shall contact an appropriate NEMT provider so that pick-up occurs within three (3) hours after the CONTRACTOR was notified when the pick-up address is in an urban area and four (4) hours after the CONTRACTOR was notified when the pick-up address is in a non-urban area. Trip mileage does not determine if a trip is urban or non-urban. As provided in Section A.4.6.2 of this Agreement, the CONTRACTOR may verify the need for an urgent trip. Failure to comply with requirements regarding urgent trips may result in liquidated damages as provided in Section 4.20.2 of the Agreement, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

- 126. Section A.5.10.1.2 of Attachment XI shall be amended by deleting and replacing the word “category” with the word “level”.**

- 127. Section A.7.1 of Attachment XI shall be amended by adding additional language to the end of the existing text as follows:**

A.7.1 The CONTRACTOR shall ensure that all vehicles meet or exceed applicable federal, state, and local requirements and manufacturer’s safety, mechanical, operating, and maintenance standards while maintaining proof of compliance as to allow for unscheduled file audits.

- 128. Section A.8.2.1 of Attachment XI shall be amended by adding a new sentence to the end of the existing text as follows:**

A.8.2.1 The CONTRACTOR shall ensure that all drivers receive appropriate training prior to providing services under the Agreement and annually thereafter. This shall include a minimum of thirty-two (32) hours of training prior to providing services under the Agreement and a minimum of fifteen (15) hours of annual training. Proof of all required training shall be maintained as to allow for unscheduled file audits.



Amendment 30 (cont.)

129. Section A.8.3.6 through A.8.3.8 and Section A.8.3.11 of Attachment XI shall be deleted and replaced as follows:

- A.8.3.6 The CONTRACTOR shall ensure that all drivers pass a physical examination prior to providing services under the Agreement and have additional physical examinations as necessary to ensure that a driver is qualified to drive a passenger vehicle (e.g., if the driver has a heart attack or stroke). The physical examination shall be at least as extensive as the medical examination required by the United States Department of Transportation's Federal Motor Carrier Safety Administration (FMCSA) for commercial drivers. Proof of exams shall be maintained in the driver file as to allow for unscheduled file audits.
- A.8.3.7 The CONTRACTOR shall ensure that all drivers pass a drug test prior to providing services under the Agreement. In addition, the CONTRACTOR shall ensure that an alcohol or drug test is conducted when a trained supervisor/employer of a driver has reasonable suspicion to believe that the driver has violated the CONTRACTOR's policies and procedures regarding use of alcohol and/or controlled substances, that random drug and alcohol tests are conducted, and that post accident drug and alcohol testing is conducted. Each driver must have at least one (1) random drug and alcohol test per year. The CONTRACTOR's policies and procedures for drug and alcohol testing shall, at a minimum, meet the FMCSA's alcohol and drug testing requirements for motor carriers. Results of drug and alcohol testing shall be maintained in the driver's file as to allow for unscheduled file audits.
- A.8.3.8 The CONTRACTOR shall ensure that criminal background checks pursuant to TCA 38-6-109 as well as national criminal background checks are conducted for all drivers prior to providing services under the Agreement and every five years thereafter. In addition, the CONTRACTOR shall ensure that random national criminal background checks are conducted. The CONTRACTOR shall develop a list of disqualifying criminal offenses, which at a minimum shall include the permanent and interim disqualifying criminal offenses that apply to applicants for a hazardous materials endorsement in Tennessee. Drivers that have been convicted or found not guilty by reason of insanity of any of the disqualifying criminal offenses shall not provide services under the Agreement. Results of background checks shall be maintained in the drivers file as to allow for unscheduled file audits.
- A.8.3.11 The CONTRACTOR shall verify that drivers are not listed on the Tennessee Sexual Offender Registry or the equivalent registry in the state of the driver's residence prior to providing services under the Agreement and every year thereafter. This is in addition to the criminal background check and results shall be maintained in the driver's file as to allow for unscheduled file audits.



Amendment 30 (cont.)

- 130. Section A.8.3.12 of Attachment XI shall be amended by adding the phrase “and annually thereafter” and Section A.8.3.12.5 shall be amended by deleting and replacing the phrase “thirty six (36)” with “twelve (12)” as follows:**

A.8.3.12 The CONTRACTOR shall ensure that drivers pass a national driver license background check prior to providing services under the Agreement and annually thereafter. This initial national driver license background check shall, at a minimum, show the following:

A.8.3.12.5 Conviction for no more than two (2) minor moving traffic violations such as speeding, failure to stop, or improper operation of a motor vehicle within the previous twelve (12) months;

- 131. Section A.8.3.13 through A.8.3.13.6 of Attachment XI shall be deleted in its entirety and the remaining Section shall be renumbered as appropriate, including any references thereto.**

- 132. The renumbered Section A.8.3 of Attachment XI shall be amended by adding a new Section A.8.3.17 as follows:**

A.8.3.17 Proof of compliance of each driver requirement shall be maintained in the driver file as to allow for unscheduled file audits.

- 133. Section A.9.3 of Attachment XI shall be deleted and replaced as follows:**

A.9.3 Between the hours of 7:00 PM and 5:00 AM in the time zone applicable to the Grand Region served by the CONTRACTOR (for example, in Middle, the applicable time zone shall be Central Time), the CONTRACTOR may use alternative arrangements to handle NEMT calls so long as there is no additional burden on the caller (e.g., the caller is not required to call a different number or to make a second call), and the call is promptly returned by the CONTRACTOR.

- 134. Section A.9.4 of Attachment XI shall be amended by adding new language to the end of the existing text as follows:**

A.9.4 For hours that the CONTRACTOR is using alternative arrangements to handle NEMT calls (see Section A.9.3 of this Attachment), the CONTRACTOR shall provide an afterhours message in, at a minimum, English and Spanish instructing the caller how to access the alternative arrangement (not requiring a second call) and also offering the caller the opportunity to leave a message utilizing a process in which all messages are returned within (3) three hours and efforts continue until the member is reached provided that the message left by the enrollee is discernible and includes a valid phone number in which the enrollee can be contacted. All efforts made to reach a member who has left a message shall be documented in order to demonstrate compliance with this requirement.

- 135. Section A.9.7 of Attachment XI shall be amended by deleting A.9.7.1 in its entirety and renumbering the remaining Section accordingly, including any references thereto and the renumbered Section A.9.7.1 shall be amended by deleting and replacing the phrase “ninety percent (90%)” with “eighty-five percent (85%)”.**



Amendment 30 (cont.)

136. Section A.9.8 of Attachment XI shall be amended by adding additional language to the end of existing text as follows:

A.9.8 If a NEMT call cannot be answered by a live voice within thirty (30) seconds, the CONTRACTOR shall provide a message in, at a minimum, English and Spanish advising the caller that the call will not be answered promptly and offering the caller the opportunity to leave a message. If the message requests the CONTRACTOR to return the call, the CONTRACTOR shall promptly return the call within three (3) hours and continue the effort until the member is reached provided that the message left by the enrollee is discernible and includes a valid phone number in which the enrollee can be contacted. All efforts made to reach a member who has left a message shall be documented in order to demonstrate compliance with this requirement.

137. Section A.9.12 of Attachment XI shall be amended by inserting the word “healthcare” in between the words “provider” and “queue” as follows:

A.9.12 The CONTRACTOR shall route incoming calls to the NEMT Call Center to, at minimum, an English-speaking member queue, a Spanish-speaking member queue, a NEMT provider queue, and a provider healthcare queue.

138. Sections A.9.14 of Attachment XI shall be amended by adding the word “healthcare” in front of the word “providers” as follows:

A.9.14 The CONTRACTOR shall develop NEMT Call Center scripts for calls requesting NEMT services that include a sequence of questions and criteria that the NEMT Call Center representatives shall use to determine the member’s eligibility for NEMT services, the appropriate mode of transportation, the purpose of the trip and all other pertinent information relating to the trip (see Section A.4 of this Attachment). The CONTRACTOR may develop additional scripts for other types of NEMT calls from members, healthcare providers, and NEMT providers. Any script for use with an enrollee shall be written at the sixth (6th) grade reading level and must be prior approved in writing by TENNCARE.

139. Section A.10.2 shall be deleted and replaced as follows:

A.10.2 The materials shall include, but not be limited to, information regarding eligibility for NEMT services, what services are covered/not covered, and how to request NEMT services, including the number to call, applicable timeframes, the approval and scheduling process, the use of fixed route, Standing Orders, and No-Show policies.

140. Section A.12.5 of Attachment XI shall be deleted and replaced as follows:

A.12.5 Notwithstanding an adequate network of providers or anything in this Agreement to the contrary, the CONTRACTOR shall provide Department of Intellectual and Developmental Disabilities (DIDD) residential and day service waiver providers the opportunity to become a NEMT provider if the provider is qualified to provide DIDD waiver transportation services (either as an individual transportation service or as a component of residential and/or day services) pursuant to provider qualifications applicable for such providers which shall be determined by DIDD. These providers shall only provide covered NEMT services to members receiving HCBS DIDD waiver services from the provider. The CONTRACTOR shall reimburse these providers for covered NEMT to TENNCARE covered services (see definition in Exhibit A) and shall not reimburse these providers for NEMT to services provided through a HCBS DIDD waiver. The CONTRACTOR shall reimburse these providers in accordance with rates paid to other NEMT providers for the provision of NEMT services.



Amendment 30 (cont.)

141. Section A.13.3 of Attachment XI shall be amended by adding a new Section A.13.3.9 as follows:

A.13.3.9 Require the NEMT provider to comply with all of the CONTRACTOR's NEMT policies and procedures, including but not limited to those policies regarding No-Shows.

142. Section A.13 of Attachment XI shall be amended by adding a new Section A.13.5 and renumbering the remaining Section accordingly, including any references thereto.

A.13.5 The CONTRACTOR shall develop and implement, subject to prior approval by TENNCARE, a template provider agreement specifically for DIDD waiver residential or day services provider which reflects only those NEMT requirements that are applicable to such providers, as may be further clarified by TENNCARE in policy or protocol.

143. Section A.14.3.1 of Attachment XI shall be deleted and replaced as follows:

A.14.3.1 The CONTRACTOR shall conduct post validation checks by matching NEMT billed claims to Healthcare provider billed claims validating two percent (2%) of NEMT claims received in a month and if the CONTRACTOR determines that transportation for a particular member was not to a TennCare covered service, the CONTRACTOR validates the next three (3) requests for that member before approving the requested trip (see Section A.4.6 of this Attachment)). If the CONTRACTOR suspects fraud or abuse, it shall comply with the fraud and abuse requirements of the Agreement.

144. Section A.17.6.1 of Attachment XI shall be deleted and replaced in its entirety.

A.17.6.1 The CONTRACTOR shall conduct a comprehensive inspection of all NEMT providers' vehicles prior to the implementation of NEMT requirements in this Attachment. Thereafter, the CONTRACTOR shall conduct a comprehensive inspection of all vehicles at least annually. The CONTRACTOR is not required to inspect fixed route vehicles, invalid vehicles, ambulances, DIDD residential or day services providers enrolled to provide NEMT for the waiver participants they serve, or vehicles for NEMT providers with which the CONTRACTOR does not have a provider agreement (see Section A.13.2 of this Attachment).

145. Section A.19 of Attachment XI shall be deleted and replaced as follows:

A.19 NEMT REPORTING

A.19.1 Approval and Utilization Reports

A.19.1.1 Approval Report. The CONTRACTOR shall submit a quarterly approval report that summarizes transportation requested, approved, modified and denied, including the modification and denial reason. The report shall provide this information by month and mode of transportation.

A.19.1.2 Pick-up and Delivery Standards Report. The CONTRACTOR shall submit a monthly report that documents the number of pick-ups that were late by a NEMT provider, and drop-offs where the member either missed or was late to an appointment and provides the average amount of time that the pick-ups or drop-offs were late.



Amendment 30 (cont.)

- A.19.1.3 Utilization Report. The CONTRACTOR shall submit a monthly utilization report that provides a summary of information on NEMT services provided to members. The report shall include, at minimum, by mode of transportation: the number of trips, number of unduplicated members, and number of miles.

A.19.2 NEMT Call Center Reports

- A.19.2.1 The CONTRACTOR shall submit a monthly report that provides a summary and detail statistics on the NEMT Call Center telephone lines/queues and includes calls received, calls answered, total calls received during regular business hours and total calls received after business hours.
- A.19.2.2 The CONTRACTOR shall submit a monthly report listing the name, position title and the identification code for all members of the call center staff.

A.19.3 NEMT Provider Enrollment File

The CONTRACTOR's monthly provider enrollment file shall include NEMT providers. In addition, the CONTRACTOR shall provide the following information to TENNCARE within timeframes described below:

- A.19.3.1 Driver Roster. The CONTRACTOR shall provide a monthly driver roster for each NEMT provider that includes, at minimum: the driver's name, license number, and social security number.
- A.19.3.2 Vehicle Listing. The CONTRACTOR shall provide a monthly vehicle listing for each NEMT provider that includes, at minimum: the type of vehicle and the vehicle's manufacturer, model, model year, and vehicle identification number.
- A.19.3.3 NEMT Provider Listing. The CONTRACTOR shall provide a monthly provider listing, identifying the providers utilized during the reporting period listing the name, whether the provider is a participating or non-participating provider, mode of transportation and the county and state of the pick-up location. This report shall give the number of participating and non-participating providers as well as a grand total of all NEMT providers.

A.19.4 NEMT Claims Management Reports

- A.19.4.1 The CONTRACTOR shall submit a monthly NEMT prompt payment report. The report shall include the number and percentage of clean NEMT claims that are processed within thirty (30) calendar days of receipt, the number and percentage of NEMT claims that are processed within sixty (60) calendar days of receipt, the number and percentage of NEMT claims and the dollar value and percentage of dollars associated with claims that are processed within the timeframes specified by TENNCARE (e.g., fifteen (15) days, thirty (30) days, etc.), and the average time (number of days) that it takes to process NEMT claims.



Amendment 30 (cont.)

- A.19.4.2 The CONTRACTOR shall submit a monthly NEMT claims payment accuracy report. The report shall be based on an audit conducted by the CONTRACTOR in accordance with Section 2.22.6 of the Agreement using a random sample of all “processed or paid” NEMT claims. The report shall include the number and percentage of NEMT claims that are paid accurately for each month.

A.19.5 NEMT Quality Assurance and Monitoring Reports

- A.19.5.1 Member NEMT Complaint Report. The CONTRACTOR shall submit a monthly member complaints report (see Section 1 of the Agreement for the definition of complaint, which includes both written and verbal statements) that details the date which the complaint was reported, the date the issue occurred, who reported the complaint, the members name, transportation provider, complaint details, date of resolution and detail of the resolution. This report shall detail complaints received about the NEMT provider.
- A.19.5.2 NEMT Provider Complaint Report. The CONTRACTOR shall submit a monthly NEMT provider complaints report that details the number of verbal and written complaints from the transportation provider about a member.
- A.19.5.3 NEMT Quality Assurance Plan. As part of its annual QM/QI reporting required by the Agreement, the CONTRACTOR shall submit an annual NEMT quality assurance plan (see Section A.17.1 of this Attachment).
- A.19.5.4 NEMT Validation Checks.
- A.19.5.4.1 The CONTRACTOR shall submit a quarterly report summarizing the pre-transportation validation checks (see Section A.4.6 of this Attachment) conducted by the CONTRACTOR,.
- A.19.5.4.2 The CONTRACTOR shall submit a quarterly report summarizing the post-transportation validation checks (see Section A.14.3 of this Attachment) conducted by the CONTRACTOR,.
- A.19.5.5 Post-Payment Review Report. The CONTRACTOR shall submit an annual report summarizing the methods and findings for the post-payment review (see Section A.17.1.2.2 of this Attachment) and identifying opportunities for improvement.
- A.19.5.6 Accidents and Incidents.
- A.19.5.6.1 Immediately upon the CONTRACTOR or the subcontracted vendor becoming aware of any accident resulting in driver or passenger injury or fatality or incidents involving abuse or alleged abuse by the driver that occurs while providing services under the Agreement, the CONTRACTOR shall notify TENNCARE. The CONTRACTOR shall submit a written accident/incident report within five (5) business days of the accident/incident and shall cooperate in any related investigation. A police report shall be included in the accident/incident report or provided as soon as possible.
- A.19.5.6.2 The CONTRACTOR shall submit a monthly report of all accidents, moving traffic violations, and incidents.
- A.19.5.6.3 Failure by the CONTRACTOR to comply with Section A.19.5.6 shall result in the application of liquidated damages as described in Exhibit F.



Amendment 30 (cont.)

A.19.5.7 Monitoring Plan.

A.19.5.7.1 The CONTRACTOR shall submit an annual NEMT provider monitoring plan (see Section A.17.3 of this Attachment).

A.19.5.7.2 The CONTRACTOR shall submit an annual report summarizing its monitoring activities, the findings, corrective actions, and improvements for NEMT services provided under the Agreement.

A.19.5.8 Satisfaction Survey Report. The CONTRACTOR shall submit a report (three months after the initial survey period and then annually) summarizing the member survey methods and findings and identifying opportunities for improvement.

146. Exhibit A of Attachment XI shall be amended by adding a new sentence to the end of the renumbered Item 18 and adding new Definitions for the terms “Urban Trip” and Non-Urban Trip” as follows:

10. Non-Urban Trip: Covered NEMT service not within a city and considered less populated, (rural as described by the US Census Bureau).

17. Urban Trip: Covered NEMT service within a city or a more populated area (not rural as described by the US Census Bureau)

18. Urgent Trip: Covered NEMT services required for an unscheduled episodic situation in which there is no immediate threat to life or limb but the enrollee must be seen on the day of the request (can be one (1) or multiple trip legs). A hospital as well as a Crisis Stabilization Unit discharge shall be an urgent trip.

147. The PERFORMANCE STANDARD/LIQUIDATED DAMAGE Chart in Exhibit F of Attachment XI shall be deleted and replaced as follows:

No.	PERFORMANCE STANDARD	LIQUIDATED DAMAGE
1	Ensure that members receive the appropriate level of service (see Section A.4.4 of this Attachment)	\$500 per deficiency
2	Comply with the approval and scheduling timeframes (see Section A.5.1.3 of this Attachment)	\$1,000 per deficiency
3	Comply with requirements regarding urgent trips (see Section A.5.7 of this Attachment)	\$1500 per deficiency
4	Comply with pick-up and delivery standards (see Section A.6 of this Attachment)	\$500 per deficiency



Amendment 30 (cont.)

No.	PERFORMANCE STANDARD	LIQUIDATED DAMAGE
5	Comply with vehicle standards (see Section A.7 of this Attachment)	<p>\$1,000 per calendar day per vehicle that is not in compliance with ADA requirements</p> <p>\$1,000 per vehicle that is allowed into service without an inspection in accordance with the requirements of the Agreement</p> <p>\$2,500 per calendar day per vehicle that is not in compliance with a vehicle standard that would endanger health or safety for vehicle occupants</p> <p>\$500 per calendar day per vehicle that is not in compliance with a vehicle standard that creates passenger discomfort or inconvenience</p> <p>\$100 per calendar day per vehicle that is not in compliance with an administrative vehicle standard</p>
6	Comply with driver training requirements and driver standards (see Section A.8 of this Attachment)	\$2,500 per calendar day per driver for each calendar day that a driver is not in compliance with the driver standards
7	85% of all calls to the NEMT Call Center are answered by a live voice within thirty (30) seconds (see Section A.9 of this Attachment)	<p>For the first deficiency: \$5,000 for each full percentage point below 85% per month per line/queue</p> <p>For the second deficiency: \$10,000 for each full percentage point below 85% per month per line/queue</p> <p>For the third and subsequent deficiencies: \$15,000 for each full percentage point below 85% per month per line/queue</p>
8	Less than 5% of calls to the NEMT Call Center are abandoned (see Section A.9 of this Attachment)	<p>For the first deficiency: \$5,000 for each full percentage point above 5% per month per line/queue</p> <p>For the second deficiency: \$10,000 for each full percentage point above 5% per month per line/queue</p> <p>For the third and subsequent deficiencies: \$15,000 for each full percentage point above 5% per month per line/queue</p>



Amendment 30 (cont.)

No.	PERFORMANCE STANDARD	LIQUIDATED DAMAGE
9	Average hold time for calls to the NEMT Call Center is no more than 3 minutes (see Section A.9 of this Attachment)	For the first deficiency: \$5,000 for each 10 seconds over 3 minutes per month per line/queue For the second deficiency: \$10,000 for each 10 seconds over 3 minutes per month per line/queue For the third and subsequent deficiencies: \$15,000 for each 10 seconds over 3 minutes per month per line/queue
10	Process 90% of clean NEMT claims within thirty (30) calendar days of the receipt of the claim and process 99.5% of claims within sixty (60) calendar of receipt (see Section A.15.3 and Section A.15.4 of this Attachment)	\$10,000 for each month determined not to be in compliance
11	97% of NEMT claims are paid accurately upon initial submission (see Section A.15.5 of this Attachment)	\$5,000 for each full percentage point accuracy is below 97% for each quarter
12	Failure by the CONTRACTOR to notify TENNCARE of an Accident/Incident in accordance with Section A.19.5.6 of this Attachment	\$1000 per occurrence



Amendment 30 (cont.)

All of the provisions of the original Agreement not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective January 1, 2013.

The State is not bound by this Amendment until it is signed by the contract parties and approved by appropriate officials in accordance with applicable Tennessee laws and regulations (depending upon the specifics of this contract, said officials may include, but are not limited to, the Commissioner of Finance and Administration, the Commissioner of Human Resources, and the Comptroller of the Treasury).

The CONTRACTOR, by signature of this Amendment, hereby affirms that this Amendment has not been altered and therefore represents the identical document that was sent to the CONTRACTOR by TENNCARE.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

VOLUNTEER STATE HEALTH PLAN,
INC.

BY: Mark A. Emkes
Mark Emkes
Commissioner

BY: Scott C. Pierce
Scott C. Pierce
President & CEO VSHP

DATE: 12/12/2012

DATE: 12-4-12

CONTRACT SUMMARY SHEET

RFS Number:	31866-00026	Edison #	29635	Contract Number:	FA-02-14632-29
State Agency:	Department of Finance and Administration			Division:	Bureau of TennCare

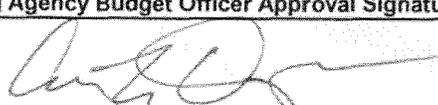
Contractor	Contract Identification Number
VSHP (TennCare Select)	<input type="checkbox"/> V- <input type="checkbox"/> C-

Service Description

Managed Care Organization / Medically Necessary Health Care Services to the TennCare/Medicaid Population

Contract Begin Date	Contract End Date
7/1/2001	6/30/2013

Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66	4A2	134	11	<input type="checkbox"/> STARS		
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)	
2002	\$6,755,937.23	\$11,843,931.25			\$18,599,868.48	
2003	\$15,785,123.40	\$17,294,819.40			\$33,079,942.80	
2004	\$25,125,990.72	\$38,364,165.90			\$63,490,156.62	
2005	\$58,007,447.00	\$58,007,447.00			\$116,014,894.00	
2006	\$87,748,111.00	\$87,748,111.00			\$175,496,222.00	
2007	\$87,748,111.00	\$87,748,111.00			\$175,496,222.00	
2008	\$72,610,000.00	\$127,390,000.00			\$200,000,000.00	
2009	\$72,610,000.00	\$127,390,000.00			\$200,000,000.00	
2010	\$100,882,479.00	\$304,024,121.00			\$404,906,600.00	
2011	\$131,085,619.00	\$312,820,981.00			\$443,906,600.00	
2012	\$149,893,942.00	\$294,012,658.00			\$443,906,600.00	
2013	\$150,102,578.00	\$293,804,022.00			\$443,906,600.00	
Total:	\$958,355,338.35	\$1,760,448,367.55			\$2,718,803,705.90	

CFDA#	93.778 Title XIX Dept. of Health & Human Svcs.	Check the box ONLY if the answer is YES:
State Fiscal Contract		
Name:	Casey Dungan	Is the Contractor a SUBRECIPIENT? (per OMB A-133)
Address:	310 Great Circle Road	Is the Contractor a Vendor? (per OMB A-133)
Phone:	Nashville, TN (615)507-6482	Is the Fiscal Year Funding STRICTLY LIMITED?
Procuring Agency Budget Officer Approval Signature		Is the Contractor on STARS?
Casey Dungan		Is the Contractor's FORM W-9 ATTACHED?
		Is the Contractor's Form W-9 Filed with Accounts?

COMPLETE FOR ALL AMENDMENTS (only)			Funding Certification
	Base Contract & Prior Amendments	This Amendment ONLY	Pursuant to T.C.A., Section 9-8-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.
CONTRACT END DATE:	6/30/2013		
FY: 2002	\$18,599,868.48		
FY: 2003	\$33,079,942.80		
FY: 2004	\$63,490,156.62		
FY: 2005	\$116,014,894.00		
FY: 2006	\$175,496,222.00		
FY: 2007	\$175,496,222.00		
FY: 2008	\$200,000,000.00		
FY: 2009	\$200,000,000.00		
FY: 2010	\$404,906,600.00		
FY: 2011	\$443,906,600.00		
FY: 2012	\$443,906,600.00		
FY: 2013	\$443,906,600.00		
Total:	\$2,718,803,705.90	\$0.00	



AMENDMENT NUMBER 29

**AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.
CONTRACT NUMBER: FA-02-14632-00**

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as specified below.

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. Section 2.23.12.2 shall be amended by adding a new Section 2.23.12.2.4 which shall read as follows:

2.23.12.2.4 The CONTRACTOR and TENNCARE agree to administer a community health record as described in Attachment XII.

2. The Contract shall be amended by adding a new ATTACHMENT XII and renumbering the existing ATTACHMENT XII as ATTACHMENT XIII. The new ATTACHMENT XII shall read as follows:

**ATTACHMENT XII
COMMUNITY HEALTH RECORD**

I. Program Requirements

1. The CONTRACTOR shall receive data files from TENNCARE for all TennCare enrollees that include the following:
 - a. Membership and eligibility file. Each daily transmission will meet the 270/271 standard transaction format.
 - b. Medical claim encounter data from all Managed Care Organizations (MCO). Each weekly transmission will include all claims processed by each MCO for the prior period.
 - c. Pharmacy claim encounter data shall be provided on a weekly basis. Each transmission will include all pharmacy claims processed for the prior period.
 - d. Provider file shall be provided on a monthly basis and shall include the National Provider Identifier for each provider; however, TENNCARE shall not be responsible for linking each provider to a common provider number for said file.



Amendment 29 (cont.)

2. The CONTRACTOR shall provide data integration services for all TennCare enrollees which include maintaining an Enterprise Master Person Index (EMPI). The EMPI provides a central repository for person-centric data from a variety of contributing systems, and facilitates the integrity of a single person record. The mission of the EMPI is to provide functionality to find the right person with the right information at the right time as well as provide a solution to identify and eliminate as many duplicate records as possible.
3. The CONTRACTOR shall provide a clinical health record for children entering State custody to the assigned Best Practice Network provider that includes the following components:
 - a. Patient Demographics;
 - b. Diagnosis and procedures from claims detail;
 - c. Medication information from claims detail;
 - d. Immunization information from claims detail; and
 - e. Allergy information, if available.
4. The CONTRACTOR shall extract, compile the information into a pdf document and transmit the clinical health record as described in Section I, Item 4 via secure email to the Department of Children Services (DCS) upon notification of a child's entry into State custody.
5. Upon notification and identification of the primary care provider assigned to a child who recently entered State custody, the CONTRACTOR shall extract, compile the information into a pdf document and transmit the clinical health record as described in Section I, Item 4 above via secure email to the assigned provider. In the event that an assigned provider doesn't provide a valid email address, the clinical health record will be transmitted via certified mail to provider's address on file.
6. The CONTRACTOR shall make updated clinical health records available to the assigned provider only upon request by the provider. The provider may make the request via telephone, email or regular USPS mail.
7. The CONTRACTOR shall maintain a log of each clinical health record that is transmitted to DCS and/or the assigned providers.
8. The CONTRACTOR shall provide a process for enrollee's to opt out of participation of the clinical health record. Upon written request, an enrollee is permitted to opt in or out of participation at any given time.
9. The CONTRACTOR shall ensure that the clinical health record does not incorporate information in the following sensitive categories:
 - a. Substance Abuse
 - b. Mental Health
 - c. Sexually Transmitted Diseases



Amendment 29 (cont.)

- d. Family Planning
- e. Genetic Testing

10. Responsibilities of TENNCARE are listed below:

- a. Provision of Data and Program Information: TENNCARE shall arrange for the following data to be provided. All data provided on a weekly basis shall be provided no later than Wednesday of the week following the data collection.
- b. Eligibility files daily that meet the requirements of the HIPAA Standard Transaction for Eligibility (270/271).
- c. Medical claim encounter data from all participating MCOs shall be provided on a weekly basis. Each weekly transmission will include all claims processed by each MCO for the prior period.
- d. Pharmacy claim encounter data shall be provided on a weekly basis. Each transmission will include all pharmacy claims processed for the prior period.
- e. Provider file shall be provided on a monthly basis and include the National Provider Identified for each provider; however, TENNCARE shall not be responsible for linking each provider to a common provider number for said file.

II. Payment Terms and Conditions:

- 1. Payment Methodology. The CONTRACTOR shall be compensated based on the payment rates herein for services authorized by the State:

Description	Implementation Fee	Monthly
Clinical Health Record Report Development	\$10,000	
Monthly Service Fee		\$45,833.33
Expenses: Certified Mail		Billed as incurred at current USPS rates for Certified Mail



Amendment 29 (cont.)

All of the provisions of the original Agreement not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective October 1, 2012.

The State is not bound by this Amendment until it is signed by the contract parties and approved by appropriate officials in accordance with applicable Tennessee laws and regulations (depending upon the specifics of this contract, said officials may include, but are not limited to, the Commissioner of Finance and Administration, the Commissioner of Human Resources, and the Comptroller of the Treasury).

The CONTRACTOR, by signature of this Amendment, hereby affirms that this Amendment has not been altered and therefore represents the identical document that was sent to the CONTRACTOR by TENNCARE.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

VOLUNTEER STATE HEALTH PLAN,
INC.

BY: Mark A. Emkes
Mark Emkes
Commissioner

BY: Scott C. Pierce
Scott C. Pierce
President & CEO VSHP

DATE: 8/31/2012

DATE: 8/28/12

CONTRACT SUMMARY SHEET



RFS Number:	31866-00026	Edison #	29635	Contract Number:	FA-02-14632-28
State Agency:	Department of Finance and Administration			Division:	Bureau of TennCare

Contractor	Contract Identification Number
VSHP (TennCare Select)	<input type="checkbox"/> V- <input type="checkbox"/> C-

Service Description

Managed Care Organization / Medically Necessary Health Care Services to the TennCare/Medicaid Population

Contract Begin Date	Contract End Date
7/1/2001	6/30/2013

Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
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Total:	\$958,355,338.35	\$1,760,448,367.55			\$2,718,803,705.90	

CFDA#	93.778 Title XIX Dept. of Health & Human Svcs.	Check the box ONLY if the answer is YES:
State Fiscal Contract		
Name:	Casey Dungan	Is the Contractor a SUBRECIPIENT? (per OMB A-133)
Address:	310 Great Circle Road Nashville, TN	Is the Contractor a Vendor? (per OMB A-133)
Phone:	(615)507-6482	Is the Fiscal Year Funding STRICTLY LIMITED?
Procuring Agency Budget Officer Approval Signature		Is the Contractor on STARS?
Casey Dungan		Is the Contractor's FORM W-9 ATTACHED?
		Is the Contractor's Form W-9 Filed with Accounts?

COMPLETE FOR ALL AMENDMENTS (only)			Funding Certification
	Base Contract & Prior Amendments	This Amendment ONLY	Pursuant to T.C.A., Section 9-6-113, I, XXXXXX , Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.
CONTRACT END DATE:	6/30/2013		
FY: 2002	\$18,599,868.48		
FY: 2003	\$33,079,942.80		
FY: 2004	\$63,490,156.62		
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FY: 2012	\$443,906,600.00		
FY: 2013	\$443,906,600.00		
Total:	\$2,718,803,705.90	\$0.00	

FA0214632-28

AMENDMENT NUMBER 28

**AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.
CONTRACT NUMBER: FA-02-14632-00**

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as specified below.

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. Section 1 shall be amended by deleting and replacing the following definitions:

At-Risk – As it relates to the CHOICES program, SSI eligible adults age sixty-five (65) and older or age twenty-one (21) or older with physical disabilities, who do not meet the established level of care criteria for nursing facility services, but have a lesser number or level of functional deficits in activities of daily living as defined in TennCare rules and regulations, such that, in the absence of the provision of a moderate level of home and community based services, the individual's condition and/or ability to continue living in the community will likely deteriorate, resulting in the need for more expensive institutional placement. As it relates to Interim CHOICES Group 3, open for enrollment only between July 1, 2012 and December 31, 2013, "at risk" is defined as adults age sixty-five (65) and older or age twenty-one (21) or older with physical disabilities who receive SSI or meet Nursing Financial eligibility criteria, and also meet the Nursing Facility level of care in effect on June 30, 2012.

CHOICES Group (Group) – One of the three groups of TennCare enrollees who are enrolled in CHOICES. There are three CHOICES groups:

1. Group 1
Medicaid enrollees of all ages who are receiving Medicaid-reimbursed care in a nursing facility.
2. Group 2
Persons age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who meet the nursing facility level of care, who qualify for TennCare either as SSI recipients or as members of the CHOICES 217-Like HCBS Group, and who need and are receiving CHOICES HCBS as an alternative to nursing facility care. The CHOICES 217-Like HCBS Group includes persons who could have been eligible under 42 CFR 435.217 had the state continued its 1915(c) HCBS waiver for elders and/or persons with physical disabilities. TENNCARE has the discretion to apply an enrollment target to this group, as described in TennCare rules and regulations.

Amendment 28 (cont.)

3. Group 3

Persons age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who qualify for TennCare as SSI recipients, who do not meet the nursing facility level of care, but who, in the absence of CHOICES HCBS, are “at-risk” for nursing facility care, as defined by the State. TENNCARE has the discretion to apply an enrollment target to this group as described in TennCare rules and regulations.

4. Interim Group 3 (open for new enrollment only between July 1, 2012, through December 31, 2013)

Persons age 65 and older and adults age 21 and older with physical disabilities who qualify for TennCare as SSI eligibles or as members of MOE Demonstration Group and who meet the NF LOC criteria in place as of June 30, 2012. There is no enrollment target on Interim Group 3.

All requirements set forth in this agreement regarding Group 3 members are applicable to Interim Group 3 members, except as explicitly stated otherwise. Interim Group 3 members are not subject to an enrollment target.

Consumer Direction of Eligible CHOICES HCBS – The opportunity for a CHOICES member assessed to need specified types of CHOICES HCBS including attendant care, personal care, in-home respite, companion care and/or any other service specified in TennCare rules and regulations as available for consumer direction to elect to direct and manage (or to have a representative direct and manage) certain aspects of the provision of such services—primarily, the hiring, firing, and day-to-day supervision of consumer-directed workers delivering the needed service(s).

Cost Neutrality Cap – The requirement that the cost of providing care to a member in CHOICES Group 2, including CHOICES HCBS and Medicaid reimbursed home health and private duty nursing, shall not exceed the cost of providing nursing facility services to the member, as determined in accordance with TennCare policy. A member’s individual cost neutrality cap shall be the average cost of Level 1 nursing facility care unless a higher cost neutrality cap is established by TENNCARE based on information submitted by the AAAD or MCO (as applicable) in the level of care application.

Eligible CHOICES HCBS – Attendant care, personal care, in-home respite, companion care services and/or any other CHOICES HCBS specified in TennCare rules and regulations as eligible for consumer direction for which a CHOICES member is determined to need and elects to direct and manage (or have a representative direct and manage) certain aspects of the provision of such services – primarily the hiring, firing and day-to-day supervision of consumer-directed workers delivering the needed service(s). Eligible CHOICES HCBS do not include home health or private duty nursing services.

Amendment 28 (cont.)

Eligible Individual – With respect to Tennessee’s Money Follows the Person Rebalancing Demonstration (MFP) and pursuant to Section 6071(b)(2) of the Deficit Reduction Act of 2005 (DRA), (Pub. L. 109-171 (S. 1932)) (Feb. 8, 2006) as amended by Section 2403 of the Patient Protection and Affordable Care Act of 2010 (ACA), (Pub. L. 111-148) (May 1, 2010), the State’s approved MFP Operational Protocol and TENNCARE Rules, a member who qualifies to participate in MFP. Such person, immediately before beginning participation in the MFP demonstration project, shall:

1. Reside in a Nursing Facility (NF) or an Intermediate Care Facility for persons with Mental Retardation (ICF/MR) and have resided for a period of not less than ninety (90) consecutive days in a Qualified Institution.
 - a. Inpatient days in an institution for mental diseases (IMDs) which includes Psychiatric Hospitals and Psychiatric Residential Treatment Facilities (PRTF) may be counted only to the extent that Medicaid reimbursement is available under the State Medicaid plan for services provided by such institution. Medicaid payments may only be applied to persons in IMDs who are over 65 or under 21 years of age.
 - b. Any days that an individual resides in a Medicare certified Skilled Nursing Facility (SNF) on the basis of having been admitted solely for purposes of receiving post-hospital short-term rehabilitative services covered by Medicare shall not be counted for purposes of meeting the ninety (90)-day minimum stay in a Qualified Institution established under ACA.
 - c. Short-term continuous care in a nursing facility, to include Level 2 nursing facility reimbursement, for episodic conditions to stabilize a condition rather than admit to hospital or to facilitate hospital discharge, and inpatient rehabilitation facility services reimbursed by the CONTRACTOR (i.e., not covered by Medicare) as a cost-effective alternative (see Section 2.6.5) and provided in a Qualified Institution shall be counted for purposes of meeting the ninety (90) day minimum stay in a Qualified Institution established under ACA.
2. Be eligible for and receive Medicaid benefits for inpatient services furnished by the nursing facility or ICF/MR for at least one (1) day. For purposes of this Agreement, an Eligible Individual must reside in a nursing facility and be enrolled in CHOICES Group 1 for a minimum of one (1) day and must be eligible to enroll and transition seamlessly into CHOICES Group 2 or CHOICES Group 3 (without delay or interruption).
3. Meet nursing facility or ICF/MR level of care, as applicable, and, but for the provision of ongoing CHOICES HCBS, continue to require such level of care provided in an inpatient facility or meet at-risk level of care such that, in the absence of the provision of a moderate level of home and community based services, the individual’s condition and/or ability to live in the community will likely deteriorate and result in the need for institutional placement.

Amendment 28 (cont.)

Home and Community-Based Services (HCBS) – Services that are provided pursuant to a Section 1915(c) waiver or the CHOICES program as an alternative to long-term care institutional services in a nursing facility or an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or to delay or prevent placement in a nursing facility. HCBS may also include optional or mandatory services that are covered by Tennessee’s Title XIX state plan or under the TennCare demonstration for all eligible enrollees, including home health or private duty nursing. However, only CHOICES HCBS are eligible for Consumer Direction. CHOICES HCBS do not include home health or private duty nursing services or any other HCBS that are covered by Tennessee’s Title XIX state plan or under the TennCare demonstration for all eligible enrollees, although such services are subject to estate recovery and shall be counted for purposes of determining whether a CHOICES member’s needs can be safely met in the community within his or her individual cost neutrality cap.

Long-Term Care (LTC)– The services of a nursing facility (NF), an Intermediate Care Facility for the Mentally Retarded (ICF/MR), or Home and Community-Based Services (HCBS). These services may also be called Long-Term Services and Supports (LTSS).

Ongoing CHOICES HCBS – Specified CHOICES HCBS which are delivered on a regular and ongoing basis, generally one or more times each week, or (in the case of community-based residential alternatives and PERS) on a continuous basis. Ongoing HCBS include community-based residential alternatives, personal care, attendant care, home-delivered meals, personal emergency response systems (PERS), and/or adult day care.

Qualified Institution – With respect to Tennessee’s MFP Rebalancing Demonstration, and pursuant to Section 6071(b)(3) of the DRA, a hospital, nursing facility, or ICF/MR.

1. An institution for mental diseases (IMDs) which includes Psychiatric Hospitals and Psychiatric Residential Treatment Facilities (PRTF) shall be a Qualified Institution only to the extent that Medicaid reimbursement is available under the State Medicaid plan for services provided by such institution. Medicaid payments may only be applied to persons in IMDs who are over 65 or under 21 years of age.
2. Any days that an individual resides in a Medicare certified Skilled Nursing Facility (SNF) on the basis of having been admitted solely for purposes of receiving post-hospital short-term rehabilitative services covered by Medicare shall not be counted for purposes of meeting the ninety (90)-day minimum stay in a Qualified Institution established under the Affordable Care Act.

TENNCARE PreAdmission Evaluation System (TPAES) – A component of the State’s Medicaid Management Information System and the system of record for all PreAdmission Evaluation (i.e., level of care) submissions and level of care determinations, as well as enrollments into and transitions between LTC programs, including CHOICES and the State’s MFP Rebalancing Demonstration (MFP), and which shall also be used to gather data required to comply with tracking and reporting requirements pertaining to MFP.

Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) – The state agency having the authority to provide care for persons with mental illness, substance abuse, and/or developmental disabilities.

Transition Allowance – A per member allotment not to exceed two thousand dollars (\$2,000) per lifetime which may, at the sole discretion of the CONTRACTOR, be provided as a cost-effective alternative to continued institutional care for a CHOICES Group 1 member in order to facilitate transition from a nursing facility to the community when such member will, upon transition to CHOICES Group 2, receive more cost-effective non-residential home and community based services or companion care. Items that may be purchased or reimbursed are only those items that the member has no other means to obtain and that are essential in order to establish a community residence when such residence is not already established and to facilitate the member’s safe and timely transition, including rent and/or utility deposits, essential kitchen appliances, basic furniture, and essential basic household items, such as towels, linens, and dishes. A Transition Allowance shall not be provided to members that no longer meet nursing facility level of care and are transitioning to CHOICES Group 3.

2. Section 1 shall be amended by adding the following new definitions:

Maintenance of Effort (MOE) – Provisions in the American Recovery and Reinvestment Act (ARRA) (Pub. L. 111–5) (Feb. 17, 2009) and the Affordable Care Act (ACA) to ensure that States’ coverage for adults under the Medicaid program remains in place and that “eligibility standards, methodologies, and procedures” are not more restrictive than those in place as of July 1, 2008 for purposes of the ARRA and March 23, 2010, for purposes of the ACA pending the establishment of specific provisions of ACA (i.e., a fully operational Exchange) on January 1, 2014.

MOE Demonstration Group – Individuals who are age 65 and older and adults age 21 and older with disabilities who (1) meet nursing home financial eligibility, (2) do not meet the nursing facility level of care criteria in place on July 1, 2012; and (3) in the absence of TennCare CHOICES services, are “at risk” of institutionalization. The MOE Demonstration Group is open only between July 1, 2012, through December 31, 2013. Individuals enrolled in the MOE Demonstration Group as of December 31, 2013, may continue to qualify in this group after December 31, 2013, so long as they (1) continue to meet Nursing Facility financial eligibility and the LOC criteria in place when they enrolled; and (2) remain continuously enrolled in the MOE Demonstration Group and in CHOICES 3.

3. Section 2.6.1.5.2.5 shall be amended by adding the phrase “but excluding Interim Group 3,” in the first sentence immediately following “3,”.

2.6.1.5.2.5 For Groups 2 and 3, but excluding Interim Group 3, if there is an enrollment target, TENNCARE determines that the enrollment target has not been met or, for Group 2, approves the CONTRACTOR’s request to provide CHOICES HCBS as a cost effective alternative (see Section 2.6.5). Enrollees transitioning from a nursing facility to the community will not be subject to the enrollment target for Group 2 but must meet categorical and financial eligibility for Group 2.

4. Section 2.6.1.5.3 and 2.6.1.5.4 shall be deleted and replaced as follows:

2.6.1.5.3 For persons determined to be eligible for enrollment in Group 2 as a result of Immediate Eligibility (as defined in Section 1 of this Agreement), the CONTRACTOR shall provide a limited package of CHOICES HCBS (personal care, attendant care, home-delivered meals, PERS, adult day care, and/or any other services as specified in TennCare rules and regulations) as identified through a needs assessment and specified in the plan of care. Upon notice that the State has determined that the member meets categorical and financial eligibility for TennCare CHOICES, the CONTRACTOR shall authorize additional services in accordance with Section 2.9.6.2.5. For members residing in a community-based residential alternative at the time of CHOICES enrollment, authorization for community-based residential alternative services shall be retroactive to the member's effective date of CHOICES enrollment.

2.6.1.5.4 The following long-term care services are available to CHOICES members, per Group, when the services have been determined medically necessary by the CONTRACTOR.

Service and Benefit Limit	Group 1	Group 2	Group 3
Nursing facility care	X	Short-term only (up to 90 days)	Short-term only (up to 90 days)
Community-based residential alternatives		X	
Personal care visits (up to 2 visits per day at intervals of no less than 4 hours between visits)		X	X
Attendant care (up to 1080 hours per calendar year; up to 1400 hours per full calendar year only for persons who require covered assistance with household chores or errands in addition to hands-on assistance with self-care tasks)		X	X
Home-delivered meals (up to 1 meal per day)		X	X
Personal Emergency Response Systems (PERS)		X	X
Adult day care (up to 2080 hours per calendar year)		X	X
In-home respite care (up to 216 hours per calendar year)		X	X
In-patient respite care (up to 9 days per calendar year)		X	X
Assistive technology (up to \$900 per calendar year)		X	X

Service and Benefit Limit	Group 1	Group 2	Group 3
Minor home modifications (up to \$6,000 per project; \$10,000 per calendar year; and \$20,000 per lifetime)		X	X
Pest control (up to 9 units per calendar year)		X	X

5. Section 2.6.5.2.5 shall be deleted and replaced as follows:

2.6.5.2.5 For CHOICES Group 1 members transitioning from a nursing facility to Group 2, a one-time transition allowance, per member. The amount of the transition allowance shall not exceed two thousand dollars (\$2,000) and may be used for items such as, but not limited to, the first month's rent and/or utility deposits, kitchen appliances, furniture, and basic household items. A Transition Allowance shall not be provided to members that no longer meet nursing facility level of care and are transitioning to CHOICES Group 3.

6. Section 2.6.5.3 shall be deleted and replaced as follows:

2.6.5.3 If the CONTRACTOR chooses to provide cost effective alternative services to a CHOICES member, in no case shall the cost of CHOICES HCBS, private duty nursing and home health care for Group 2 exceed a member's cost neutrality cap nor the total cost of CHOICES HCBS, excluding minor home modifications, for members in Group 3 exceed the expenditure cap. The total cost of CHOICES HCBS includes all covered CHOICES HCBS and other non-covered services that the CONTRACTOR elects to offer as a cost effective alternative to nursing facility care for CHOICES Group 2 members pursuant to Section 2.6.5.2 of this Agreement including, as applicable: CHOICES HCBS in excess of specified benefit limits, the one-time transition allowance for CHOICES Group 1 members who are transitioning to CHOICES Group 2, and NEMT for Groups 2 and 3.

7. Sections 2.6.7.2.2.3 shall be amended by deleting the reference to Section "2.9.6.3" and replacing it with "2.9.6.8".

2.6.7.2.2.3 If the CONTRACTOR is unable to find an alternate nursing facility willing to serve the member and the member otherwise qualifies to enroll in CHOICES Group 2, the CONTRACTOR shall determine if it can safely and effectively serve the member in the community and within the cost neutrality cap. If it can, and the CONTRACTOR is willing to continue serving a member who has failed to pay his or her patient liability or if TENNCARE determines that the member would not have patient liability in the community setting, the member shall be offered a choice of CHOICES HCBS. If the member chooses CHOICES HCBS, the CONTRACTOR shall forward all relevant information to TENNCARE for a decision regarding transition to Group 2 (Section 2.9.6.8).

8. Sections 2.6.7.2.3.2 through 2.6.7.2.3.2.2 shall be deleted and replaced as follows:

- 2.6.7.2.3.2 The CONTRACTOR shall collect patient liability from CHOICES Group 2 and Group 3 members (as applicable) who receive CHOICES HCBS in his/her own home or who receive adult day care services and from Group 2 members who receive Companion Care.
- 2.6.7.2.3.2.1 The CONTRACTOR shall use calculated patient liability amounts to offset the cost of CHOICES Group 2 or CHOICES Group 3 benefits (or CEA services provided as an alternative to covered CHOICES Group 2 or Group 3 benefits) reimbursed by the CONTRACTOR for that month.
- 2.6.7.2.3.2.2 The CONTRACTOR shall not collect patient liability that exceeds the cost of CHOICES Group 2 or CHOICES Group 3 benefits (or CEA services provided as an alternative to CHOICES Group 2 or Group 3 benefits) reimbursed by the CONTRACTOR for that month.

9. Section 2.6.7.2.3.3 shall be amended by adding the phrase “or Group 3” after “If a Group 2” as follows:

- 2.6.7.2.3.3 If a Group 2 or Group 3 member fails to pay required patient liability, pursuant to Section 2.6.1.5.8.6, the CONTRACTOR may request to no longer provide long-term care services to the member.

10. The last sentence of Section 2.7.1.3 shall be amended by deleting the space between the word “non-emergency”.

11. Sections 2.9.2.1.4.6.2 through 2.9.2.1.4.6.4 shall be deleted and replaced as follows:

- 2.9.2.1.4.6.2 Transition Group 1 members to CHOICES HCBS unless the member chooses to receive CHOICES HCBS as an alternative to nursing facility care and is enrolled in CHOICES Group 2 or the member meets the at-risk level of care and is enrolled in CHOICES Group 3 (see Section 2.9.6.8 for requirements regarding nursing facility to community transition);
- 2.9.2.1.4.6.3 Admit a member in CHOICES Group 2 to a nursing facility unless the member meets the nursing facility level of care in place at the time of admission and (1) is expected to require short-term nursing facility services for ninety (90) days or less; (2) the member chooses to transition to a nursing facility and enroll in Group 1; or (3) the CONTRACTOR determines that it cannot safely and effectively meet the needs of the member and within the member’s cost neutrality cap, and the member agrees to transition to a nursing facility and enroll in Group 1;
- 2.9.2.1.4.6.4 Admit a member enrolled in CHOICES Group 3 to a nursing facility unless the member meets the nursing facility level of care in place at the time of admission and (1) is expected to require short-term nursing facility services for ninety (90) days or less; or (2) the member chooses to transition to a nursing facility and enroll in Group 1; or

12. Section 2.9.6.1.6.1 shall be deleted and replaced as follows:

2.9.6.1.6.1 The day of the initiating event (e.g., receipt of a referral for CHOICES screening and intake or notification of a new CHOICES member on the outbound 834 enrollment file) shall be the anchor date and is not to be included in the timeline computation;

13. Section 2.9.6.2.3.1 shall be deleted and replaced as follows:

2.9.6.2.3.1 For persons wishing to apply for CHOICES, TENNCARE or its designee may employ a screening process, using the tools and protocols specified by TENNCARE, to assist with intake for persons new to both TennCare and CHOICES. Such screening process shall assess: (1) whether the applicant appears to meet categorical and financial eligibility criteria for CHOICES; (2) whether the applicant appears to meet level of care eligibility for enrollment in CHOICES; and (3) for applicants seeking access to CHOICES HCBS through enrollment in CHOICES Group 2, whether it appears that the applicant's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care.

14. Section 2.9.6.2.3.4 and 2.9.6.2.3.5 shall be deleted and replaced as follows:

2.9.6.2.3.4 As part of the intake visit, TENNCARE or its designee shall: (1) provide general CHOICES education and information, as specified by TENNCARE, and assist in answering any questions the applicant may have; (2) provide information about estate recovery; (3) complete Medicaid and level of care (i.e., PAE) applications and provide assistance, as necessary, in gathering documentation needed by the State to determine TennCare eligibility; (4) provide choice counseling and facilitate the selection of an MCO by the applicant or his/her representative; (5) for applicants seeking enrollment in CHOICES Group 1 or Group 2, provide information regarding freedom of choice of nursing facility versus CHOICES HCBS, both verbally and in writing, and obtain a Freedom of Choice form signed and dated by the applicant or his/her representative; (6) provide detailed information and obtain signed acknowledgement of understanding regarding a CHOICES member's responsibility with respect to payment of patient liability amounts, including, as applicable, the potential consequences for non-payment of patient liability which may include loss of the member's current nursing facility or CBRA provider or MCO, disenrollment from CHOICES, and to the extent the member's eligibility is dependent on receipt of long-term care services, possible loss of eligibility for TennCare; (7) for applicants who want to receive NF services, provide information regarding the completion of all PASRR requirements prior to nursing facility admission and conduct the level I PASRR screening; (8) for applicants who are seeking CHOICES HCBS: (a) conduct a risk assessment using a tool and protocol specified by TENNCARE and develop, as applicable, a risk agreement that shall be signed by the applicant or his/her representative and which shall include identified risks to the applicant, the consequences of such risks, strategies to mitigate the identified risks, and the applicant's decision regarding his/her acceptance of risk; and (b) provide information regarding consumer direction and obtain signed documentation of the applicant's interest in participating in consumer direction; (9) for applicants who are seeking enrollment in Group 2, identify the services that may be needed by the applicant upon enrollment in Group 2, make a determination regarding whether the applicant's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care, and provide explanation to the applicant regarding the individual cost neutrality cap, including that a change in a member's needs or circumstances that would result in the

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cost neutrality cap being exceeded or that would result in the MCO's inability to safely and effectively meet a member's needs in the community and within the cost neutrality cap may result in the member's disenrollment from CHOICES Group 2, in which case, the care coordinator will assist with transition to a more appropriate care delivery setting; (10) for applicants who are seeking enrollment in Group 3, identify the covered HCBS that may be needed by the applicant upon enrollment in Group 3 and provide explanation to the applicant regarding the fifteen thousand dollars (\$15,000) expenditure cap; and (11) for all applicants, provide information regarding next steps in the process including the need for approval by TENNCARE to enroll in CHOICES and the functions of the CONTRACTOR, including that the CONTRACTOR will develop and approve a plan of care.

2.9.6.2.3.5 The listing of CHOICES HCBS and home health and/or private duty nursing services the member may need shall be used by TENNCARE or its designee to determine whether services can be provided within the member's cost neutrality cap (applicable only for Group 2) and may be further refined based on the CONTRACTOR's comprehensive needs assessment and plan of care development processes.

15. Section 2.9.6.2.4.3 shall be amended by adding new language to the end of the existing language as follows:

2.9.6.2.4.3 The CONTRACTOR shall not transition members in Group 1 to CHOICES HCBS unless the member chooses to receive CHOICES HCBS as an alternative to nursing facility and is enrolled in Group 2 or a member enrolled in CHOICES on or after July 1, 2012 no longer meets nursing facility level of care but does meet the at-risk level of care and is enrolled in Group 3.

16. Section 2.9.6.2.5.3 shall be amended by adding the phrase "in Group 2" after the word "enrolled" in the first sentence.

2.9.6.2.5.3 The care coordinator shall, for all other CHOICES members in Groups 2 and 3 not specified in 2.9.6.2.5.1 – 2.9.6.2.5.2 above, within ten (10) business days of notice of the member's enrollment in CHOICES, conduct a face-to-face visit with the member, perform a comprehensive needs assessment (see Section 2.9.6.5), develop a plan of care (see Section 2.9.6.6), and authorize and initiate CHOICES HCBS, except in the case of members enrolled in Group 2 on the basis of Immediate Eligibility in which case only the limited package of CHOICES HCBS shall be authorized and initiated. Members enrolled on the basis of Immediate Eligibility shall have access only to a limited package of CHOICES HCBS (see Section 2.6.1.5.3) pending determination of categorical and financial eligibility for TennCare CHOICES; however all needed services shall be listed in the plan of care, and the CONTRACTOR shall immediately revise the service authorizations as necessary upon notice that the State has determined that the member meets categorical and financial eligibility for TennCare CHOICES and initiate services within ten (10) business days of notice.

17. Sections 2.9.6.2.5.5 and 2.9.6.2.5.6 shall be deleted and replaced as follows:

2.9.6.2.5.5 The CONTRACTOR shall not admit a member enrolled in CHOICES Group 2 to a nursing facility unless the member meets nursing facility level of care in place at the time of admission and (1) is expected to require short-term nursing facility services for ninety (90) days or less; (2) chooses to transition to a nursing facility and enroll in Group 1; or (3) the CONTRACTOR determines that it cannot safely and effectively meet the needs of a Group 2 member and at a cost that is less than the member's cost neutrality cap and the member agrees to transition to a nursing facility and enroll in Group 1.

2.9.6.2.5.6 The CONTRACTOR shall not admit a member enrolled in CHOICES Group 3 to a nursing facility unless the member meets nursing facility level of care in place at the time of admission and: (1) is expected to require short-term nursing facility services for ninety (90) days or less; or (2) chooses to transition to a nursing facility and enroll in Group 1.

18. Section 2.9.6.3.2 shall be deleted and replaced as follows:

2.9.6.3.2 As part of its identification process for members who may be eligible for CHOICES, the CONTRACTOR may initiate a telephone screening process, using the tool and protocols specified by TENNCARE. Such screening process shall: (1) verify the member's current eligibility category based on information provided by TENNCARE in the outbound 834 enrollment file; for persons seeking access to CHOICES HCBS through enrollment in CHOICES Groups 2 or 3, identify whether the member meets categorical eligibility requirements for enrollment in such group based on his/her current eligibility category, and if not, whether the member appears to meet categorical and financial eligibility criteria for the Institutional (i.e., CHOICES 217-Like HCBS or MOE Demonstration) category; (2) determine whether the member appears to meet level of care eligibility for CHOICES; and (3) for members seeking access to CHOICES HCBS through enrollment in CHOICES Group 2, determine whether it appears that the member's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care. Such telephone screening shall be conducted at the time of the initial call by the CONTRACTOR unless the member requests that the screening be conducted at another time, which shall be documented in writing in the CHOICES intake record.

19. Section 2.9.6.3.9 shall be deleted and replaced as follows:

2.9.6.3.9 As part of the face-to-face intake visit, the care coordinator shall: (1) provide general CHOICES education and information, as specified by TENNCARE, to the member and assist in answering questions the member may have; (2) provide information about estate recovery; (3) provide assistance, as necessary, in gathering documentation needed by DHS to determine categorical/financial eligibility for LTC; (4) for members seeking enrollment in CHOICES Group 1 or Group 2, provide information regarding freedom of choice of nursing facility versus CHOICES HCBS, both verbally and in writing, and obtain a Freedom of Choice form signed and dated by the member or his/her representative; (5) provide detailed information and signed acknowledgement of understanding regarding a CHOICES member's responsibility with respect to payment of patient liability amounts, including, as applicable, the potential consequences for non-payment of patient liability which may include loss of the member's current nursing facility or CBRA provider or MCO, disenrollment from CHOICES, and to the extent the member's eligibility is dependent on receipt of long-term care services, possible loss of eligibility for TennCare; and (6) for members who want to receive nursing facility

services, provide information regarding the completion of all PASRR requirements prior to nursing facility admission and conduct the level I PASRR screening; (7) for members who are seeking CHOICES HCBS, the care coordinator, shall: (a) conduct a risk assessment using a tool and protocol specified by TENNCARE and shall develop, as applicable, a risk agreement that shall be signed and dated by the member or his/her representative and which shall include identified risks to the member, the consequences of such risks, strategies to mitigate the identified risks, and the member's decision regarding his/her acceptance of risk; and (b) provide information regarding consumer direction and obtain written confirmation of the member's decision regarding participation in consumer direction; (8) for members seeking enrollment in Group 2, make a determination regarding whether the person's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care, and provide explanation to the member regarding the individual cost neutrality cap, including that a change in needs or circumstances that would result in the cost neutrality cap being exceeded or that would result in the CONTRACTOR's inability to safely and effectively meet the member's needs in the community and within the cost neutrality cap may result in the member's disenrollment from CHOICES Group 2, in which case, the member's care coordinator will assist with transition to a more appropriate care delivery setting; (9) for members seeking enrollment in Group 3, provide explanation to the member regarding the fifteen thousand dollar (\$15,000) expenditure cap; ; and (10) for all members, provide information regarding choice of contract providers, subject to the provider's availability and willingness to timely deliver services, and obtain signed documentation of the member's choice of contract providers.

20. Section 2.9.6.3.14 shall be deleted and replaced as follows:

2.9.6.3.14 Once completed, in the manner prescribed by TENNCARE the CONTRACTOR shall submit the level of care and, for members requesting CHOICES Group 2 HCBS, documentation, as specified by TENNCARE, to verify that the member's needs can be safely and effectively met in the community and within the cost neutrality cap to TENNCARE as soon as possible but no later than five (5) business days of the face-to-face visit. The CONTRACTOR shall make every effort to obtain supporting documentation required for the level of care in a timely manner and shall document in writing the cause of any delay in the submission of the required documentation to TENNCARE, including the CONTRACTOR's actions to mitigate such delay. The CONTRACTOR shall be responsible for ensuring that the level of care is accurate and complete, satisfies all technical requirements specified by TENNCARE, and accurately reflects the member's current medical and functional status based on information gathered, at a minimum, from the member, his or her representative, the Care Coordinator's direct observations, and the history and physical or other medical records which shall be submitted with the application. The CONTRACTOR shall note in the level of care any discrepancies between these sources of information, and shall provide explanation regarding how the CONTRACTOR addressed such discrepancies in the level of care.

21. Section 2.9.6.3.16 shall be deleted and replaced as follows:

2.9.6.3.16 The CONTRACTOR shall be responsible for (1) advising members who appear to meet the nursing facility level of care that are seeking access to CHOICES HCBS through enrollment in CHOICES Group 2 when an enrollment target has been (or will soon be) reached; (2) advising such persons that they may choose to receive nursing facility

services if CHOICES Group 2 HCBS are not immediately available; (3) determining whether the person wants nursing facility services if CHOICES Group 2 HCBS are not immediately available; and (4) at the CONTRACTOR's sole discretion, making a determination regarding whether enrollment in Group 2 constitutes a CEA because the immediate provision of nursing facility services will otherwise be required and submitting appropriate documentation to TENNCARE if there is a waiting list for CHOICES Group 2 but the CONTRACTOR chooses to enroll a member in Group 2 as a CEA (see Section 2.9.6.3.15.1).

22. Section 2.9.6.3.20 shall be deleted and replaced as follows:

2.9.6.3.20 For the CONTRACTOR's current members enrolled into CHOICES Group 2 or Group 3, the member's Care Coordinator shall within ten (10) business days of notice of the member's enrollment in CHOICES Group 2 or Group 3, authorize and initiate CHOICES HCBS.

23. Section 2.9.6.3.20.3 shall be deleted and replaced as follows:

2.9.6.3.20.3 The CONTRACTOR shall provide at least verbal notice to the member prior to initiation of CHOICES HCBS identified in the plan of care regarding any change in providers selected by the member for each CHOICES HCBS; including the reason such change has been made. If the CONTRACTOR is unable to place a CHOICES Group 1 or 2 member in the nursing facility or community-based residential alternative setting requested by the member, the care coordinator shall meet with the member and his/her representative to discuss the reasons why the member cannot be placed with the requested facility and the available options and identify an alternative facility.

24. Sections 2.9.6.3.20.7 through 2.9.6.3.20.9 shall be deleted and replaced as follows:

2.9.6.3.20.7 The CONTRACTOR shall not divert or transition members in CHOICES Group 1 to CHOICES HCBS unless the member chooses to receive CHOICES HCBS as an alternative to nursing facility and is enrolled in Group 2 or a member enrolled in CHOICES on or after July 1, 2012 no longer meets nursing facility level of care but does meet the at-risk level of care and is enrolled in Group 3.

2.9.6.3.20.8 The CONTRACTOR shall not admit a member enrolled in CHOICES Group 2 to a nursing facility unless the member meets the nursing facility level of care in place at the time of admission and : (1) is expected to require a short-term nursing facility care stay for ninety (90) days or less; (2) chooses to transition to a nursing facility and enroll in Group 1; or (3) the CONTRACTOR determines that it cannot safely and effectively meet the needs of the member and at a cost that is less than the member's cost neutrality cap and the member agrees to transition to a nursing facility and enroll in Group 1.

2.9.6.3.20.9 The CONTRACTOR shall not admit a member enrolled in CHOICES Group 3 to a nursing facility unless the member meets the nursing facility level of care in place at the time of admission and: (1) is expected to require short-term nursing facility services for ninety (90) days or less; or (2) chooses to transition to a nursing facility and enroll in Group 1.

- 25. Section 2.9.6.4.3.2 shall be amended by deleting the reference to Section “2.9.6.3.19” and replacing it with “2.9.6.3.20”.**

2.9.6.4.3.2 For CHOICES members who, upon enrollment in CHOICES, are not receiving services in a nursing facility or a community-based residential alternative setting, the CONTRACTOR shall assign a specific care coordinator and shall advise the member of the name of his/her care coordinator and provide contact information prior to the initiation of services (see Section 2.9.6.2.5.3 and 2.9.6.3.20), but no more than ten (10) calendar days following CHOICES enrollment.

- 26. Section 2.9.6.6.2.4 shall be amended by adding the phrase “in CHOICES Group 2” in items (4) and (5) as follows:**

2.9.6.6.2.4 The plan of care developed for CHOICES members in Groups 2 and 3 prior to initiation of CHOICES HCBS shall at a minimum include: (1) pertinent demographic information regarding the member including the name and contact information of any representative and a list of other persons authorized by the member to have access to health care (including long-term care) related information and to assist with assessment, planning, and/or implementation of health care (including long-term care) related services and supports; (2) care, including specific tasks and functions, that will be performed by family members and other caregivers; (3) home health, private duty nursing, and long-term care services the member will receive from other payor sources including the payor of such services; (4) home health and private duty nursing that will be authorized by the CONTRACTOR, except in the case of persons enrolled in CHOICES Group 2 on the basis of Immediate Eligibility who shall have access to services beyond the limited package of CHOICES HCBS (see Section 2.6.1.5.3) only upon determination of categorical and financial eligibility for TennCare; (5) CHOICES HCBS that will be authorized by the CONTRACTOR, including the amount, frequency, duration, and scope (tasks and functions to be performed) of each service to be provided, and the schedule at which such care is needed, as applicable; members enrolled in CHOICES Group 2 on the basis of Immediate Eligibility shall have access only to a limited package of CHOICES HCBS (see Section 2.6.1.5.3) pending determination of categorical and financial eligibility for TennCare CHOICES however all identified needed services shall be listed in the plan of care; (6) a detailed back-up plan for situations when regularly scheduled HCBS providers are unavailable or do not arrive as scheduled; the back-up plan may include paid and unpaid supports and shall include the names and telephone numbers of persons and agencies to contact and the services provided by listed contacts; the CONTRACTOR shall assess the adequacy of the back-up plan; and (7) for CHOICES Group 2 members, the projected TennCare monthly and annual cost of home health and private duty nursing identified in (4) above, and the projected monthly and annual cost of CHOICES HCBS specified in (5) above, and for CHOICES Group 3 members, the projected total cost of CHOICES HCBS specified in (5) above, excluding the cost of minor home modifications.

27. Section 2.9.6.8 shall be deleted and replaced as follows:

2.9.6.8 Nursing Facility-to-Community Transition

- 2.9.6.8.1 As applicable, including when directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the CONTRACTOR shall develop and implement methods for identifying members who may have the ability and/or desire to transition from a nursing facility to the community. Such methods shall include, at a minimum:
- 2.9.6.8.1.1 Referrals, including but not limited to, treating physician, nursing facility, other providers, community-based organizations, family, and self-referrals;
- 2.9.6.8.1.2 Identification through the care coordination process, including but not limited to: assessments, information gathered from nursing facility staff, participation in Grand Rounds (as defined in Section 1) or review and assessment of members whose nursing facility level of care is ending and who appear to meet the at-risk level of care for Group 3.
- 2.9.6.8.1.3 Review and analysis of members identified by TENNCARE based on Minimum Data Set (MDS) data from nursing facilities.
- 2.9.6.8.2 Members in CHOICES Group 1 (who are residents of a nursing facility) and who are under the age of twenty-one (21) and have requested to transition home will be provided coordination of care by the CONTRACTOR's CHOICES and MCO Case Management staff (see Section 2.9.5.4.1).
- 2.9.6.8.3 Notwithstanding the nursing facility-to-community transition requirements set forth in this section (2.9.6.8.), the CONTRACTOR shall be responsible for monitoring all Group 1 members' level of care eligibility (see Section 2.9.6.8.1.2.) and for completing the process to re-establish nursing facility level of care or transition to Group 3 HCBS, as appropriate, prior to expiration of nursing facility level of care.
- 2.9.6.8.4 For transition referrals by or on behalf of a nursing facility resident, regardless of referral source, the CONTRACTOR shall ensure that within fourteen (14) days of the referral a care coordinator conducts an in-facility visit with the member to determine the member's interest in and potential ability to transition to the community, and provide orientation and information to the member regarding transition activities. The member's care coordinator/care coordination team shall document in the member's case file that transition was discussed with the member and indicate the member's wishes as well as the member's potential for transition. The CONTRACTOR shall not require a member to transition from Group 1 to Group 2 when the member expresses a desire to continue receiving nursing facility services.
- 2.9.6.8.5 For identification by the CONTRACTOR by means other than referral or the care coordination process of a member who may have the ability and/or desire to transition from a nursing facility to the community, the CONTRACTOR shall ensure that within ninety (90) days of such identification a care coordinator conducts an in-facility visit with the member to determine whether or not the member is interested in and potential ability to pursue transition to the community. The member's care coordinator/care coordination team shall document in the member's case file that transition was discussed with the member and indicate the member's wishes as well as the member's potential for transition. The CONTRACTOR shall not require a member to transition when the member expresses a desire to continue receiving nursing facility services.

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- 2.9.6.8.6 If the member wishes to pursue transition to the community, within fourteen (14) days of the initial visit (see Sections 2.9.6.8.3 and 2.9.6.8.4 above) or within fourteen (14) days of identification through the care coordination process, the care coordinator shall conduct an in-facility assessment of the member's ability and/or desire to transition using tools and protocols specified or prior approved in writing by TENNCARE. This assessment shall include the identification of any barriers to a safe transition.
- 2.9.6.8.7 As part of the transition assessment, the care coordinator shall conduct a risk assessment using a tool and protocol specified by TENNCARE, discuss with the member the risk involved in transitioning to the community and shall begin to develop, as applicable, a risk agreement that shall be signed and dated by the member or his/her representative and which shall include identified risks to the member, the consequences of such risks, strategies to mitigate the identified risks, and the member's decision regarding his/her acceptance of risk as part of the plan of care. The risk agreement shall include the frequency and type of care coordinator contacts that exceed the minimum contacts required (see Section 2.9.6.9.4), to mitigate any additional risks associated with transition and shall address any special circumstances due to transition. For members transitioning to Group 2, the member's care coordinator/care coordination team shall also make a determination regarding whether the member's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care. The member's care coordinator shall explain to the member the individual cost neutrality cap and obtain a signed acknowledgement of understanding by the member or his/her representative that a change in a member's needs or circumstances that would result in the cost neutrality cap being exceeded or that would result in the CONTRACTOR's inability to safely and effectively meet a member's needs in the community and within the cost neutrality cap may result in the member's disenrollment from CHOICES Group 2, in which case, the CONTRACTOR will assist with transition to a more appropriate care delivery setting. For members transitioning to Group 3, the care coordinator shall explain the expenditure cap.
- 2.9.6.8.8 For those members whose transition assessment indicates that they are not candidates for transition to the community, the care coordinator shall notify them in accordance with the specified transition assessment protocol.
- 2.9.6.8.9 For those members whose transition assessment indicates that they are candidates for transition to the community, the care coordinator shall facilitate the development of and complete a transition plan within fourteen (14) days of the member's transition assessment.
- 2.9.6.8.10 The care coordinator shall include other individuals such as the member's family and/or caregiver in the transition planning process if the member requests and/or approves, and such persons are willing and able to participate.
- 2.9.6.8.11 As part of transition planning, prior to the member's physical move to the community, the care coordinator shall visit the residence where the member will live to conduct an on-site evaluation of the physical residence and meet with the member's family or other caregiver who will be residing with the member (as appropriate). The care coordinator shall include in the transition plan activities and/or services needed to mitigate any perceived risks in the residence including but not limited to an increase in face-to-face visits beyond the minimum required contacts in Sections 2.9.6.8.19 and 2.9.6.8.20.
- 2.9.6.8.12 The transition plan shall address all services necessary to safely transition the member to the community and include at a minimum member needs related to housing, transportation,

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availability of caregivers, and other transition needs and supports. The transition plan shall also identify any barriers to a safe transition and strategies to overcome those barriers.

- 2.9.6.8.13 The CONTRACTOR shall approve the transition plan and authorize any covered or cost effective alternative services included in the plan within ten (10) business days of completion of the plan. The transition plan shall be fully implemented within ninety (90) days from approval of the transition plan, except under extenuating circumstances which must be documented in writing.
- 2.9.6.8.14 The member's care coordinator shall also complete a plan of care that meets all criteria described in Section 2.9.6.6 for members in CHOICES Groups 2 and 3 including but not limited to completing a comprehensive needs assessment, completing and signing the risk agreement and making a final determination of cost neutrality. The plan of care shall be authorized and initiated prior to the member's transition to the community.
- 2.9.6.8.14.1. If a transitioning member is enrolled in CHOICES Group 1, any CHOICES HCBS that must be completed prior to a member's transition from a nursing facility to the community in order to ensure the member's health and safety upon transition (e.g., minor home modifications, adaptive equipment, or PERS installation) shall be completed while the member is enrolled in Group 1, but shall be billed as a Group 2 service once the member is enrolled into Group 2, with the date of service the effective date of enrollment in CHOICES Group 2 (see State Medicaid Director Letter, Olmstead Update No. 3, July 25, 2000).
- 2.9.6.8.14.2. If a transitioning member is enrolled in CHOICES Group 2 or 3 but is receiving short-term nursing facility care, any CHOICES HCBS that must be completed prior to a member's transition from a nursing facility to the community in order to ensure the member's health and safety upon transition (e.g., minor home modifications, adaptive equipment, or PERS installation) shall be completed while the member resides in the facility and billed as a Group 2 or Group 3 service, as applicable. However, a member shall not be transitioned from CHOICES Group 1 into Group 2 or 3 for receipt of short-term nursing facility services in order to provide these services. Short-term nursing facility care is available only to a CHOICES 2 or CHOICES 3 participant who was receiving home and community based services *upon admission* to the short-term nursing facility stay.
- 2.9.6.8.15 For members requesting transition from Group 1 to Group 2, the CONTRACTOR shall not prohibit a member from transitioning to the community once the member has been counseled regarding risk. However, the CONTRACTOR may determine that the member's needs cannot be safely and effectively met in the community and at a cost that does not exceed nursing facility care. In such case, the CONTRACTOR shall seek written review and approval from TENNCARE prior to denial of any member's request to transition to the community. If TENNCARE approves the CONTRACTOR's request, the CONTRACTOR shall notify the member in accordance with TennCare rules and regulations and the transition assessment protocol, and the member shall have the right to appeal the determination (see Section 2.19.3.12 of this Agreement).

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- 2.9.6.8.16 Once completed, the CONTRACTOR shall submit to TENNCARE documentation, as specified by TENNCARE to verify that for members transitioning to Group 2, the member's needs can be safely and effectively met in the community and within the cost neutrality cap. Before transitioning a member, the CONTRACTOR shall verify that the member has been approved for enrollment in CHOICES Group 2 or Group 3, as applicable, effective as of the planned transition date.
- 2.9.6.8.17 Ongoing CHOICES HCBS and any medically necessary covered home health or private duty nursing services needed by the member shall be initiated immediately upon transition from a nursing facility (i.e., CHOICES Group 1) to the community (i.e., CHOICES Group 2 or CHOICES Group 3) and as of the effective date of transition with no gaps between the member's receipt of nursing facility services and ongoing CHOICES HCBS.
- 2.9.6.8.18 The member's care coordinator/care coordination team shall monitor all aspects of the transition process and take immediate action to address any barriers that arise during transition.
- 2.9.6.8.19 For members transitioning to a setting other than a community-based residential alternative setting, the care coordinator/care coordination team shall upon transition utilize the EVV system to monitor the initiation and daily provision of services in accordance with the member's new plan of care, and shall take immediate action to resolve any service gaps (see definition in Section 1).
- 2.9.6.8.20 For members who will live independently in the community or whose on-site visit during transition planning indicated an elevated risk, within the first twenty-four (24) hours, the care coordinator shall visit the member in his/her residence. During the initial ninety (90) day post-transition period, the care coordinator shall conduct monthly face-to-face in-home visits to ensure that the plan of care is being followed, that the plan of care continues to meet the member's needs, and the member has successfully transitioned to the community.
- 2.9.6.8.21 For members transitioning to a community-based residential alternative setting or who will live with a relative or other caregiver, within the first twenty-four (24) hours the care coordinator shall contact the member and within seven (7) days after the member has transitioned to the community, the care coordinator shall visit the member in his/her new residence. During the initial ninety (90) day post-transition period, the care coordinator shall (1) at a minimum, contact the member by telephone each month to ensure that the plan of care is being followed, that the plan of care continues to meet the member's needs, and the member has successfully transitioned to the community; and (2) conduct additional face-to-face visits as necessary to address issues and/or concerns and to ensure that the member's needs are met.
- 2.9.6.8.22 The CONTRACTOR shall monitor hospitalizations and nursing facility re-admission for members who transition from a nursing facility to the community to identify issues and implement strategies to improve transition outcomes.
- 2.9.6.8.23 The CONTRACTOR shall be permitted to coordinate or subcontract with local community-based organizations to assist in the identification, planning and facilitation processes related to nursing facility-to-community transitions that are not specifically assigned to the care coordinator.

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- 2.9.6.8.24 The CONTRACTOR shall develop and implement any necessary assessment tools, transition plan templates, protocols, or training necessary to ensure that issues that may hinder a member's successful transition are identified and addressed. Any tool, template, or protocol must be prior approved in writing by TENNCARE.
- 2.9.6.8.25 To facilitate nursing facility to community transition, the CONTRACTOR may elect to use specialized transition coordinators or transition teams. All transition activities identified as responsibilities of the care coordinator shall be completed by an individual who meets all of the requirements to be a care coordinator.
- 2.9.6.8.26 The CONTRACTOR shall implement policies and processes necessary to ensure that it is aware when a member is admitted to or discharged from a NF in order to facilitate care planning and as seamless a transition as possible, and to ensure timely notification to TENNCARE and other entities (e.g., DHS) as appropriate.
- 2.9.6.8.26.1 The CONTRACTOR shall require NFs to notify the CONTRACTOR of all NF discharges, transfers between NFs, or elections of hospice services in a NF.
- 2.9.6.8.26.2 The CONTRACTOR shall, in a manner prescribed by TENNCARE notify: a) TENNCARE of all NF discharges and elections of hospice services in a NF; b) DHS of all NF discharges and transfers between NFs; and c) receiving NFs of all applicable level of care information when a member is transferring between NFs.
- 2.9.6.8.26.3 The CONTRACTOR shall conduct a census as frequently as deemed necessary by TENNCARE to confirm the residency status and Group assignment of all CHOICES members (i.e., Group 1 receiving services in a NF or Group 2 receiving HCBS or short-term NF services). The CONTRACTOR shall take actions as necessary to address any discrepancies when a CHOICES member is found to no longer be receiving LTC services, or is receiving services in a different service delivery setting, e.g., NF, HCBS, or hospice in a NF, including, as appropriate, disenrollment from CHOICES and/or enrollment in a different CHOICES Group.
- 2.9.6.8.26.4 The CONTRACTOR shall authorize and/or reimburse short-term NF stays for Group 2 and Group 3 members only when (1) the member meets the nursing facility level of care in place at the time of admission; (2) the member's stay in the facility is expected to be less than ninety (90) days; and (3) the member is expected to return to the community upon its conclusion. The CONTRACTOR shall monitor all short-term NF stays for Group 2 and Group 3 members and shall ensure that the member is transitioned from Group 2 or Group 3, as applicable, to Group 1 at any time a) it is determined that the stay will not be short-term or the member will not transition back to the community; and b) prior to exhausting the ninety (90)-day short-term NF benefit covered for CHOICES Group 2 and Group 3 members.
- 2.9.6.8.26.4.1 Upon request, the CONTRACTOR shall provide to TENNCARE a member-by-member status for each Group 2 and Group 3 member utilizing the short-term NF stay benefit, including but not limited to the name of each Group 2 and Group 3 member receiving short-term NF services, the NF in which s/he currently resides, the date of admission for short-term stay, and the anticipated date of discharge back to the community.

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- 28. Section 2.9.6.9.4.3.3 shall be amended by adding the phrase “or Group 3” after the phrase “CHOICES Group 2”.**

2.9.6.9.4.3.3 Members in CHOICES Group 2 or Group 3 who have transitioned from a nursing facility to the community shall be contacted per the applicable timeframe specified in Section 2.9.6.8.

- 29. Sections 2.9.6.9.4.3.7 through 2.9.6.9.4.3.9 shall be deleted and replaced as follows:**

2.9.6.9.4.3.7 Members in CHOICES Group 2 or Group 3 shall be contacted by their care coordinator at least monthly either in person or by telephone with an interval of at least fourteen (14) days between contacts. These members shall be visited in their residence face-to-face by their care coordinator at least quarterly with an interval of at least sixty (60) days between visits.

2.9.6.9.4.3.8 Members in CHOICES Group 2 or Group 3 participating in MFP shall, for at least the first ninety (90) days following transition to the community, be visited in their residence face-to-face by their care coordinator at least monthly with an interval of at least fourteen (14) days between contacts to ensure that the plan of care is being followed, that the plan of care continues to meet the member’s needs, and the member has successfully transitioned back to the community. Thereafter, for the remainder of the member’s MFP participation period, minimum contacts shall be as described in 2.9.6.9.4.3.7 unless more frequent contacts are required based on the member’s needs and circumstances and as reflected in the member’s plan of care, or based on a significant change in circumstances (see Sections 2.9.6.9.2.1.16. and 2.9.8.4.5) or a short-term nursing facility stay (see Sections 2.9.8.8.5 and 2.9.8.8.7).

- 30. Sections 2.9.6.9.6.3.3 and 2.9.6.9.6.3.4 shall be deleted and replaced as follows:**

2.9.6.9.6.3.3 For members whose plan of care includes eligible CHOICES HCBS, written confirmation of the member’s decision regarding participation in consumer direction of eligible CHOICES HCBS;

2.9.6.9.6.3.4 A completed risk assessment and a risk agreement signed and dated by the member or his/her representative; and

- 31. Section 2.9.6.11.6.1.1 shall be amended by adding the phrase “or Group 3” after the phrase “CHOICES Group 2”.**

2.9.6.11.6.1.1 Upon completion of a Transition Assessment which indicates that a Group 1 member is a candidate for transition to the community, such member shall be factored into the weighted caseload and staffing ratio calculations using an acuity level of two and one-half (2.5) until such time as the member is transitioned to CHOICES Group 2 or Group 3 or the member is no longer a candidate for transition;

- 32. Section 2.9.6.11.6.2 shall be amended by adding the phrase “or Group 3” after the phrase “CHOICES Group 2”.**

2.9.6.11.6.2 Each CHOICES Group 2 or Group 3 member shall be factored into the weighted caseload and staffing ratio calculations utilizing an acuity level of two and one-half (2.5);

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33. Sections 2.9.6.11.6.3 and 2.9.6.11.6.4 shall be amended by deleting and replacing the header of the charts as follows:

2.9.6.11.6.3. Using the delineated acuity factors, the following provides examples of the composition of caseloads with a weighted value of 125:

Weighted Caseload Mix for a 1:125 Ratio		
CHOICES Group 1 (Acuity 1.0)	CHOICES Group 2 and Group 3 (Acuity 2.5)	Total CHOICES Members on Caseload
125	0	125
100	10	110
75	20	95
50	30	80
25	40	65
0	50	50

2.9.6.11.6.4. Using the delineated acuity factors, the following delineates the composition of caseloads with a weighted value of 175:

Weighted Caseload Mix for a 1:175 Ratio		
CHOICES Group 1 (Acuity 1.0)	CHOICES Group 2 and Group 3 (Acuity 2.5)	Total CHOICES Members on Caseload
175	0	175
150	10	160
125	20	145
100	30	130
75	40	115
50	50	100
25	60	85
0	70	70

34. Section 2.9.6.11.8 shall be deleted and replaced as follows:

2.9.6.11.8 Upon request, the CONTRACTOR shall provide to TENNCARE documentation of such monitoring, including an itemized list by care coordinator of the total number of members assigned, and the number of Group 1 members (including members in transition and children under age 21), Group 2 and Group 3 members that comprise each care coordinator's caseload.

35. Section 2.9.6.11.18.1 shall be deleted and replaced as follows:

2.9.6.11.18.1 The CHOICES program including a description of the CHOICES groups; eligibility for CHOICES enrollment; enrollment in CHOICES; enrollment targets for Groups 2 and 3 (excluding Interim Group 3), including reserve capacity and administration of waiting lists; and CHOICES benefits, including benefit limits, the individual cost neutrality cap for Group 2, the expenditure cap for Group 3, and the limited benefit package for Group 2 members enrolled on the basis of Immediate Eligibility;

36. Section 2.9.6.11.18.17 shall be deleted and replaced as follows:

2.9.6.11.18.17 For all CHOICES members, as applicable, members' responsibility regarding patient liability, including the consequences of not paying patient liability;

37. Section 2.9.6.13.1 shall be deleted and replaced as follows:

2.9.6.13.1 The CONTRACTOR shall use the TENNCARE PreAdmission Evaluation System (TPAES), the system of record for CHOICES level of care determinations, to facilitate submission of all PreAdmission Evaluation (i.e., level of care) applications, including required documentation pertaining thereto, and to facilitate enrollments into and transitions between LTC programs, including CHOICES. The CONTRACTOR shall comply with all data entry and tracking processes and timelines established by TENNCARE in policy or protocol in order to ensure efficient and effective administration and oversight of the CHOICES program.

38. Section 2.9.7.4.1 shall be amended by deleting the reference to "Section 2.9.6.2.4" and replacing it with the reference to "Section 2.9.6.2.5" and Section 2.9.7.4.3.3 shall be amended by adding the phrase "or Group 3" after the phrase "CHOICES Group 2" and Section 2.9.7.4.3.4 shall be amended by deleting the phrase "Group 2" at the end of the sentence.

2.9.7.4.3.3 For any CHOICES Group 2 or Group 3 member electing to participate in consumer direction that refuses to receive eligible CHOICES HCBS from contract providers while services are initiated through consumer direction, the member's care coordinator shall visit the member face to face at least monthly to ensure that the member's needs are safely met, and shall continue to offer eligible CHOICES HCBS through contract providers.

2.9.7.4.3.4 If eligible CHOICES HCBS are not initiated within sixty (60) days following referral to the FEA, the CONTRACTOR shall notify the member that eligible CHOICES HCBS must be initiated by contract providers unless these HCBS are not needed on an ongoing basis in order to safely meet the member's needs in the community, in which case, the CONTRACTOR shall submit documentation to TENNCARE to begin the process of disenrollment from CHOICES.

39. Section 2.9.8.1.2 shall be amended by adding the phrase “or Group 3” after the phrase “CHOICES Group 2”.

2.9.8.1.2 Eligible Individuals transitioning to a Qualified Residence in the community and consenting to participate in MFP shall be transitioned from CHOICES Group 1 into CHOICES Group 2 or Group 3 pursuant to TENNCARE policies and protocols for Nursing Facility-to-community transitions and shall also be enrolled into MFP. For persons enrolled in CHOICES who are also participating in MFP, the CONTRACTOR shall comply with all applicable provisions of this Agreement pertaining to the CHOICES program. This section sets forth additional requirements pertaining to the CONTRACTOR’s responsibilities specifically as it relates to MFP.

40. Section 2.9.8.2.2 shall be amended by adding the phrase “or Group 3” after the phrase “CHOICES Group 2”.

2.9.8.2.2 The CONTRACTOR shall assess all nursing facility residents transitioning from the NF to CHOICES Group 2 or Group 3 for participation in MFP. This includes CHOICES Group 1 members referred for transition, as well as nursing facility residents referred for CHOICES who are not yet enrolled in CHOICES Group 1 but may be determined eligible for Group 1, and who have expressed a desire to move back into the community. However, the resident must actually be enrolled into Group 1 in order to qualify for MFP.

41. Sections 2.9.8.3.3 and 2.9.8.3.4 shall be deleted and replaced as follows:

2.9.8.3.3 Only CHOICES Group 1 members who qualify to enroll in CHOICES Group 2 or Group 3 shall be eligible to transition to Group 2 or Group 3, as applicable, and enroll into MFP.

2.9.8.3.4 In addition to facilitating transition from CHOICES Group 1 to CHOICES Group 2 or Group 3 pursuant to Section 2.9.6.8 of this Agreement and TENNCARE’s policies and protocols, the CONTRACTOR shall facilitate the enrollment of Eligible Individuals who consent into MFP.

42. Sections 2.9.8.4.6 and 2.9.8.4.12 shall be amended by adding the phrase “or Group 3, as applicable” after the phrase “CHOICES Group 2”.

2.9.8.4.6 The CONTRACTOR shall review the circumstances which resulted in the inpatient facility admission and shall evaluate whether the services and supports provided to the member are sufficient to safely meet his needs in the community such that continued participation in CHOICES Group 2 or Group 3, as applicable, and in MFP is appropriate.

2.9.8.4.12 The CONTRACTOR shall, using a template provided by TENNCARE, issue a written notice of MFP participation to each member enrolled in MFP which shall not occur prior to transition from CHOICES Group 1 to CHOICES Group 2 or Group 3, as applicable. Such notice shall be issued within ten (10) business days of notification from TENNCARE via the outbound 834 enrollment file furnished by TENNCARE to the CONTRACTOR that the member is enrolled in MFP.

43. Sections 2.9.8.5.1, 2.9.8.6.1, and 2.9.8.7.1 shall be amended by adding the phrase “or Group 3, as applicable” after the phrase “CHOICES Group 2”.

2.9.8.5.1 For members participating in the MFP, the Plan of Care shall reflect that the member is an MFP participant, including the date of enrollment into MFP (i.e., date of transition from CHOICES Group 1 to CHOICES Group 2 or Group 3, as applicable).

2.9.8.6.1 A member enrolled in MFP shall be simultaneously enrolled in CHOICES Group 2 or Group 3, as applicable, and shall be eligible to receive covered benefits as described in 2.6.1

2.9.8.7.1 Upon completion of a person’s 365-day participation in MFP, services (including CHOICES HCBS) shall continue to be provided in accordance with the covered benefits described in 2.6.1 and the member’s plan of care. Transition from participation in MFP and CHOICES Group 2 or Group 3, as applicable, to participation *only* in CHOICES Group 2 or Group 3, as applicable, shall be seamless to the member, except that the CONTRACTOR shall be required to issue notice of the member’s conclusion of his 365-day MFP participation period.

44. Sections 2.9.8.8.1 and 2.9.8.8.2 shall be deleted and replaced as follows:

2.9.8.8.1 A CHOICES Group 2 or Group 3 member that meets the nursing facility level of care in place at the time of admission may be admitted for an inpatient short-term nursing facility stay for up to ninety (90) days and remain enrolled in CHOICES Group 2 or Group 3, as applicable (see Section 2.6.1.5.4). The CONTRACTOR shall ensure that the member is transitioned from Group 2 or Group 3, as applicable, to Group 1 at any time: a) it is determined that the stay will not be short-term and the member will not transition back to the community; and b) prior to exhausting the ninety (90) day short-term nursing facility benefit covered for CHOICES Group 2 or Group 3 members (see Section 2.9.6.8.26.4).

2.9.8.8.2 A CHOICES Group 2 or Group 3 member participating in MFP who meets the nursing facility level of care in place at the time of admission may be admitted for an inpatient short-term nursing facility stay during his 365-day participation period and remain enrolled in MFP regardless of the number of days the member is admitted for inpatient facility care.

45. Sections 2.9.8.8.4 shall be deleted and replaced as follows:

2.9.8.8.4 If the short-term stay will exceed ninety (90) days, the CONTRACTOR shall facilitate transition from CHOICES Group 2 or Group 3 if the Group 3 member continues to meet nursing facility level of care to CHOICES Group 1.

46. Sections 2.9.8.8.6 shall be amended by adding the phrase “or Group 3” after the phrase “CHOICES Group 2”.

2.9.8.8.6 The CONTRACTOR shall conduct a Transition Assessment and develop a Transition Plan (see Section 2.9.6.8) as necessary to facilitate the member’s return to the community. Such assessment shall include a review of the circumstances which resulted in the nursing facility admission and shall evaluate whether the services and supports provided to the member are sufficient to safely meet his needs in the community such that transition back to CHOICES Group 2 or Group 3 and continued participation in MFP is appropriate. The CONTRACTOR shall update the member’s plan of care, including the member’s Risk Agreement, as deemed necessary based on the member’s needs and circumstances.

47. Section 2.9.8.11.1 shall be amended by deleting the reference to “Section 2.9.6.12.6” and replacing it with the reference to “Section 2.9.6.12.7”.

48. Section 2.9.8.13.1.5.2 shall be amended by adding the phrase “and Group 3” after the phrase “CHOICES Group 2”.

2.9.8.13.1.5.2 Immediately prior to implementation of MFP and at the beginning of each calendar year thereafter, statewide calendar year numbers for benchmark #5 will be allocated on a regional basis to each MCO operating in the region, based on the number of persons in CHOICES Group 2 and Group 3. For purposes of incentive payments (see Section 3.11), achievement of this benchmark shall be determined on a regional basis by MCO.

49. Sections 2.9.16.1 and 2.9.16.5 shall be deleted and replaced as follows and Section 2.9.16 shall be amended by adding Section 2.9.16.7 and the remaining Section shall be renumbered accordingly.

2.9.16.1 Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) and Tennessee Department of Intellectual and Developmental Disabilities (DIDD) for the purpose of interfacing with and assuring continuity of care and for coordination of specialized services in accordance with federal PASRR requirements;

2.9.16.5 Tennessee Department of Intellectual Disabilities Services (DIDD), for the purposes of coordinating physical and behavioral health services with HCBS available for members who are also enrolled in a Section 1915(c) HCBS waiver for persons with intellectual disabilities, i.e., mental retardation;

2.9.16.7 Tennessee Department of Education (DOE) and local education agencies for the purposes of coordinating educational services in compliance with the requirements of Individuals with Disabilities Education Act (IDEA) and to ensure school-based services for students with special needs are provided;

2.9.16.7.1 The CONTRACTOR is responsible for the delivery of medically necessary covered services to school-aged children. MCOs are encouraged to work with school-based providers to manage the care of students with special needs. The State has implemented a process, referred to as TENNderCARE Connection, to facilitate notification of MCOs when a school-aged child enrolled in TennCare has an Individualized Education Plan (IEP) that identifies a need

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for medical services. In such cases, the school is responsible for obtaining parental consent to share the IEP with the MCO and for subsequently sending a copy of the parental consent and IEP to the MCO. The school is also responsible for clearly delineating the services on the IEP that the MCOs are to consider for payment. If a school-aged member, needing medical services, is identified by the CONTRACTOR by another means, the CONTRACTOR shall request the IEP from the appropriate school system.

2.9.16.7.2 The CONTRACTOR shall designate a contact person to whom correspondence concerning children with medical services included in their IEPs will be directed. After receipt of an IEP, the CONTRACTOR shall:

2.9.16.7.2.1 Either accept the IEP as indication of a medical problem and treat the IEP as a request for service or assist in making an appointment to have the child evaluated by the child's PCP or another contract provider. If the CONTRACTOR does not accept the documentation provided with the IEP as indication of a medical problem, the CONTRACTOR shall have the child re-evaluated in order to make a decision about the appropriateness of the requested service.

2.9.16.7.2.2 Send a copy of the IEP and any related information (e.g. action taken by the MCO in response to receipt of the IEP, action the MCO expects the PCP to take) to the PCP.

2.9.16.7.2.3 Notify the designated school contact of the ultimate disposition of the request (e.g. what services have been approved for the child, what arrangements have been made for service delivery) within 14 days of the CONTRACTOR's receipt of the IEP.

50. Section 2.12.4 shall be deleted and replaced with "LEFT BLANK INTENTIONALLY".

2.12.4 LEFT BLANK INTENTIONALLY

51. Section 2.13.4.4 shall be amended by deleting the reference to "Section 2.9.6.7" and replacing it with "Section 2.9.7.6.11".

52. Section 2.14.1.2 shall be amended by adding a new Section 2.14.1.2.1 as follows:

2.14.1.2.1 The UM program description, work plan and program evaluation shall be exclusive to TENNCARE and shall not contain documentation from other state Medicaid programs or product lines operated by the CONTRACTOR.

53. Section 2.15.1.1.6 shall be amended by deleting the word "and" at the end of the sentence, Section 2.15.1.1.7 shall be amended by deleting and replacing the "." with "; and", and Section 2.15.1.1 shall be amended by adding a new Section 2.15.1.1.8 as follows:

2.15.1.1.8 The QM/QI program description, work plan and program evaluation shall be exclusive to TENNCARE and shall not contain documentation from other state Medicaid programs or product lines operated by the CONTRACTOR.

54. Section 2.17.4.7.11 shall be amended by adding the phrase “(excluding Interim Group 3)” after the phrase “Group 2 and Group 3”.

2.17.4.7.11 Shall include information on the CHOICES program, including a description of the CHOICES groups; eligibility for CHOICES; enrollment in CHOICES, including whom to contact at the MCO regarding enrollment in CHOICES; enrollment targets for Group 2 and Group 3 (excluding Interim Group 3), including reserve capacity and administration of waiting lists; and CHOICES benefits, including benefit limits, the individual cost neutrality cap for Group 2, and the expenditure cap for Group 3;

55. Section 2.17.7.3.12 shall be deleted and replaced as follows:

2.17.7.3.12 Information about patient liability responsibilities including the potential consequences of failure to comply with patient liability requirements. For Group 1 members, this may include loss of the member’s nursing facility provider; for Group 2 members, loss of the member’s CBRA provider; and for all CHOICES members, loss of the member’s MCO, disenrollment from CHOICES, and to the extent that the member’s eligibility depends on receipt of long-term care services, loss of eligibility for TennCare;

56. Section 2.20.2 shall be deleted and replaced as follows:

2.20.2 Reporting and Investigating Suspected Fraud and Abuse

2.20.2.1 The CONTRACTOR shall cooperate with all appropriate state and federal agencies, including TBI MFCU and/or OIG, in investigating fraud and abuse. In addition, the CONTRACTOR shall fully comply with the TCA 71-5-2601 and 71-5-2603 in performance of its obligations under this Agreement.

2.20.2.2 The CONTRACTOR shall have methods for identification, investigation, and referral of suspected fraud cases (42 CFR 455.13, 455.14, 455.21).

2.20.2.3 The CONTRACTOR shall notify TBI MFCU and TennCare Office of Program Integrity simultaneously and in a timely manner regarding all internal (such as identified patterns of data mining outliers, audit concerns, critical incidences) and external (such as hotline calls) tips with potential implications to TennCare providers' billing anomalies and/or to safety of TennCare enrollees (http://www.tbi.state.tn.us/tbi_tips.shtml; ProgramIntegrity.TennCare@tn.gov). Along with a notification, the CONTRACTOR shall take steps to triage and/or substantiate these tips and provide simultaneous and timely updates to TBI MFCU and the TennCare Office of Program Integrity when the concerns and/or allegations of any tips are authenticated.

2.20.2.4 The CONTRACTOR shall report all confirmed or suspected fraud and abuse to TENNCARE and the appropriate agency as follows:

2.20.2.4.1 Suspected fraud and abuse in the administration of the program shall be reported to TennCare Office of Program Integrity, TBI MFCU and/or OIG;

2.20.2.4.2 All confirmed or suspected provider fraud and abuse shall immediately be reported to TBI MFCU and TennCare Office of Program Integrity; and

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- 2.20.2.4.3 All confirmed or suspected enrollee fraud and abuse shall be reported immediately to OIG.
- 2.20.2.5 The CONTRACTOR shall use the Fraud Reporting Forms in Attachment VI, or such other form as may be deemed satisfactory by the agency to whom the report is to be made under the terms of this Agreement.
- 2.20.2.6 Pursuant to TCA 71-5-2603(c) the CONTRACTOR shall be subject to a civil penalty, to be imposed by the OIG, for willful failure to report fraud and abuse by recipients, enrollees, applicants, or providers to TENNCARE and OIG or TBI MFCU, as appropriate.
- 2.20.2.7 The CONTRACTOR shall promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud and abuse. Unless prior written approval is obtained from the agency to whom the incident was reported, or to another agency designated by the agency that received the report, after reporting fraud or suspected fraud and/or suspected abuse and/or confirmed abuse, the CONTRACTOR shall not take any of the following actions as they specifically relate to TennCare claims:
 - 2.20.2.7.1 Contact the subject of the investigation about any matters related to the investigation;
 - 2.20.2.7.2 Enter into or attempt to negotiate any settlement or agreement regarding the incident; or
 - 2.20.2.7.3 Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.
- 2.20.2.8 The CONTRACTOR shall promptly provide the results of its preliminary investigation to the agency to whom the incident was reported, or to another agency designated by the agency that received the report.
- 2.20.2.9 The CONTRACTOR shall cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation shall include providing, upon request, information, access to records, and access to interview CONTRACTOR employees and consultants, including but not limited to those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation.
- 2.20.2.10 The State shall not transfer its law enforcement functions to the CONTRACTOR.
- 2.20.2.11 The CONTRACTOR, subcontractor and providers, whether contract or non-contract, shall, upon request and as required by this Agreement or state and/or federal law, make available to the TBI MFCU/OIG any and all administrative, financial and medical records relating to the delivery of items or services for which TennCare monies are expended. In addition, the TBI MFCU/OIG shall, as required by this Agreement or state and/or federal law, be allowed access to the place of business and to all TennCare records of any contractor, subcontractor or provider, whether contract or non-contract, during normal business hours, except under special circumstances when after hour admission shall be allowed. Special circumstances shall be determined by the TBI MFCU/OIG.
- 2.20.2.12 The CONTRACTOR and/or subcontractors shall include in any of its provider agreements a provision requiring, as a condition of receiving any amount of TennCare payment, that the provider comply with this Section, Section 2.20 of this Agreement.

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- 2.20.2.13 The CONTRACTOR shall notify TENNCARE when the CONTRACTOR denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.
- 2.20.2.14 Except as described in Section 2.11.8.2 of this Agreement, nothing herein shall require the CONTRACTOR to ensure non-contract providers are compliant with TENNCARE contracts or state and/or federal law.
- 2.20.2.15 In accordance with the Affordable Care Act and TennCare policy and procedures, the CONTRACTOR shall report overpayments made by TENNCARE to the CONTRACTOR as well as overpayments made by the CONTRACTOR to a provider and/or subcontractor (See Section 2.12.9.42).

57. Section 2.22.1 shall be amended by deleting the word “and” between the words “filing,” and “compliance” and by adding new language to the end of the section.

2.22.1 General

To the extent that the CONTRACTOR compensates providers on a fee-for-service or other basis requiring the submission of claims as a condition of payment, the CONTRACTOR shall process, as described herein, the provider’s claims for covered benefits provided to members consistent with applicable CONTRACTOR policies and procedures and the terms of this Agreement including but not limited to timely filing, compliance with all applicable state and federal laws, rules and regulations, including the development, staff and provider education and training, and implementation of all state and federal standardization initiatives (e.g., 5010, ICD 10, etc.) within the designated guidelines and timeframes specified by TENNCARE and/or CMS.

58. Section 2.25.9 shall be deleted in its entirety.

59. Section 2.26.1 shall be amended by adding a new Section 2.26.1.3 as follows and renumbering the remaining Section accordingly, including any references thereto.

- 2.26.1.3 Effective with any new subcontracts or upon the next amendment to existing subcontracts, the CONTRACTOR shall include a requirement that the subcontract may be terminated by the CONTRACTOR for convenience and without cause upon a specified number of days written notice.

60. Section 2.29.1.3.13 shall be deleted and replaced as follows:

- 2.29.1.3.13 At least one full-time investigator per operating region and a staff person responsible for all fraud and abuse detection activities, including the fraud and abuse compliance plan, as set forth in Section 2.20 of this Agreement. The investigator will have full knowledge with provider investigations related to the TennCare program and will be the key staff handling day-to-day provider investigation related inquires from TENNCARE;

61. Section 2.29.1.3.29 shall be amended by deleting “TDMHDD” and replacing it with “TDMHSAS”.

62. Section 2.30.4.3 shall be deleted and replaced as follows:

2.30.4.3 The CONTRACTOR shall submit a quarterly *Behavioral Health Crisis Response Report* that provides information on behavioral health crisis services (see Section 2.7.2.8) including the data elements described by TENNCARE. Specified data elements shall be reported separately for members ages eighteen (18) years and over and those under eighteen (18) years and all data elements shall be reported for each individual crisis service provider as described in the template provided by TENNCARE.

63. Sections 2.30.6.4 and 2.30.6.6 shall be amended by deleting the reference to “Section 2.9.6.8” and replacing it with the reference to “Section 2.9.8” and Item (1) of Section 2.30.6.9 shall be amended by adding the phrase “or Group 3” after the phrase “CHOICES Group 2”.

- (1) The total number and the name and SSN of each CHOICES Group 2 or Group 3 member enrolled into MFP;

64. Section 2.30.9 shall be deleted and replaced as follows:

2.30.9 LEFT BLANK INTENTIONALLY

65. Sections 2.30.11.5, 2.30.12.7, and 2.30.17.5 shall be amended by deleting the reference to “Section 2.9.6.8” and replacing it with the reference to “Section 2.9.8”.

66. Section 2.30.22.1 shall be amended by adding the word “also” between the words “shall” and “demonstrate” in the second sentence.

67. The PROGRAM ISSUES Column in Items A.16 and A.29 of the Liquidated Damages Chart in Section 5.20.2.2.7 shall be amended by adding the phrase “or 3” after the phrase “Group 2”.

LEVEL	PROGRAM ISSUES	DAMAGE
<p>A.16</p>	<p>Failure to comply with the timeframes for developing and approving a plan of care for transitioning CHOICES members in Group 2 or 3, authorizing and initiating nursing facility services for transitioning CHOICES members in Group 1, or initiating long-term care services for CHOICES members (see Sections 2.9.2, 2.9.3, and 2.9.6)</p>	<p>\$5,000 per month that the CONTRACTOR’s performance is 85-89% by service setting (nursing facility or HCBS) \$10,000 per month that the CONTRACTOR’s performance is 80-84% by service setting (nursing facility or HCBS) \$15,000 per month that the CONTRACTOR’s performance is 75-79% by service setting (nursing facility or HCBS) \$20,000 per month that the CONTRACTOR’s performance is 70-74% by service setting (nursing facility or HCBS) \$25,000 per month that the CONTRACTOR’s performance is 69% or less by service setting (nursing facility or HCBS)</p> <p>These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing recommendations as specified in Section 2.9.6.11.9 of this Agreement</p>
<p>A.29</p>	<p>Failure to initiate CHOICES HCBS or for children under age 21, EPSDT benefits provided as an alternative to nursing facility care in accordance with the member’s plan of care and to ensure that such HCBS or EPSDT benefits are in place immediately upon transition from a nursing facility to the community for any person transitioning from a nursing facility (i.e., CHOICES Group 1) to the community (i.e., CHOICES Group 2 or 3), including persons enrolled in MFP (see Sections 2.9.5.4.1.5 and 2.9.6.8.16)</p>	<p>\$500 per day for each day that HCBS are not in place following transition from a nursing facility (i.e., CHOICES Group 1) to the community (i.e., CHOICES Group 2) in addition to the cost of services not provided</p> <p>These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing recommendations as specified in Section 2.9.6.11.9 of this Agreement</p>

68. The Liquidated Damages Chart in Section 5.20.2.2.7 shall be amended by deleting and replacing Items B.15 and B.21 as follows and by adding new Items B.17 and B.23 as follows and renumbering the existing Sections accordingly, including any references thereto.

B.15	Failure to send collection notices to providers as described in Section 2.30.10.6 of this Agreement		\$100 per provider notice per month
B.17	Failure to require and ensure compliance with Ownership and Disclosure requirements as required in Section 2.12.9.43 of this Agreement Failure to maintain complete and current disclosures/attestations for all providers excluding providers billing under emergency provisions		\$5,000 per provider disclosure/attestation for each disclosure/attestation that is not received or is received and signed by a provider that does not request or contain complete and satisfactory disclosure of the requirements outlined in 42 CFR 455, Subpart B. 92 to 95% Compliance - \$5000 per each full percentage point below 95% Under 92% Compliance - \$10,000 per each full percentage point below 95%
B.21	Failure to provide a written discharge plan or provision of a defective discharge plan for discharge from a psychiatric inpatient facility or mental health residential treatment facility as required in Section 2.9.10.3.2 of this Agreement		\$1,000 per occurrence per case
B.23	Failure to meet any timeframe regarding care coordination for CHOICES members (see Sections 2.9.2, 2.9.3, and 2.9.6) other than the timeframes referenced in A.16 or A.17		\$5,000 per month for each timeframe that the CONTRACTOR's performance is 85-89% \$10,000 per month for each timeframe that the CONTRACTOR's performance is 80-84% \$20,000 per month for each timeframe that the CONTRACTOR's performance is 75-79% \$50,000 per month for each timeframe that the CONTRACTOR's performance is 70-74% \$100,000 per month for each timeframe that the CONTRACTOR's performance is 69% or less These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing recommendations as specified in Section 2.9.6.11.9 of this Agreement

- 69. Section 5 shall be amended by adding a new Section 5.40 and renumbering the remaining Section 5 as appropriate, including any references thereto.**

5.40 SOCIAL SECURITY ADMINISTRATION (SSA) REQUIRED PROVISIONS FOR DATA SECURITY

The CONTRACTOR shall comply with limitations on use, treatment, and safeguarding of data under the Privacy Act of 1974 (5 U.S.C. §552a), as amended by the Computer Matching and Privacy Protection Act of 1988, related Office of Management and Budget guidelines, the Federal Information Security Management Act of 2002 (44 U.S.C. § 3541, *et seq.*), and related National Institute of Standards and Technology guidelines. In addition, the CONTRACTOR shall have in place administrative, physical, and technical safeguards for data.

- 5.40.1 The CONTRACTOR shall not duplicate in a separate file or disseminate, without prior written permission from TENNCARE, the data governed by the Contract for any purpose other than that set forth in this Contract for the administration of the TennCare program. Should the CONTRACTOR propose a redisclosure of said data, the CONTRACTOR must specify in writing to TENNCARE the data the CONTRACTOR proposes to redisclose, to whom, and the reasons that justify the redisclosure. TENNCARE will not give permission for such redisclosure unless the redisclosure is required by law or essential to the administration of the TennCare program.
- 5.40.2 The CONTRACTOR agrees to abide by all relevant federal laws, restrictions on access, use, and disclosure, and security requirements in this Contract.
- 5.40.3 Upon request, the CONTRACTOR shall provide a current list of the employees of such CONTRACTOR with access to SSA data and provide such lists to TENNCARE.
- 5.40.4 The CONTRACTOR shall restrict access to the data obtained from TENNCARE to only those authorized employees who need such data to perform their official duties in connection with purposes identified in this Contract. The CONTRACTOR shall not further duplicate, disseminate, or disclose such data without obtaining TENNCARE's prior written approval.
- 5.40.5 The CONTRACTOR shall ensure that its employees:
- 5.40.5.1 Properly safeguard PHI/PII furnished by TENNCARE under this Contract from loss, theft or inadvertent disclosure;
 - 5.40.5.2 Understand that they are responsible for safeguarding this information at all times, regardless of whether or not the CONTRACTOR employee is at his or her regular duty station;
 - 5.40.5.3 Ensure that laptops and other electronic devices/ media containing PHI/PII are encrypted and/or password protected;
 - 5.40.5.4 Send emails containing PHI/PII only if encrypted or if to and from addresses that are secure; and
 - 5.40.5.5 Limit disclosure of the information and details relating to a PHI/PII loss only to those with a need to know.

CONTRACTOR employees who access, use, or disclose TennCare or TennCare SSA-supplied data in a manner or purpose not authorized by this Contract may be subject to civil and criminal sanctions pursuant to applicable federal statutes.

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- 5.40.6 Loss or Suspected Loss of Data – If an employee of the CONTRACTOR becomes aware of suspected or actual loss of PHI/PII, he or she must immediately contact TENNCARE **within one (1) hour** to report the actual or suspected loss. The CONTRACTOR will use the Loss Worksheet located at http://www.tn.gov/tenncare/forms/phi_piiworksheet.pdf to quickly gather and organize information about the incident. The CONTRACTOR must provide TENNCARE with timely updates as any additional information about the loss of PHI/PII becomes available.
- 5.40.6.1 If the CONTRACTOR experiences a loss or breach of said data, TENNCARE will determine whether or not notice to individuals whose data has been lost or breached shall be provided and the CONTRACTOR shall bear any costs associated with the notice or any mitigation.
- 5.40.7 TENNCARE may immediately and unilaterally suspend the data flow under this Contract, or terminate this Contract, if TENNCARE, in its sole discretion, determines that the CONTRACTOR has: (1) made an unauthorized use or disclosure of TennCare SSA-supplied data; or (2) violated or failed to follow the terms and conditions of this Contract.
- 5.40.8 Legal Authority
- 5.40.8.1 Federal laws and regulations giving SSA the authority to disclose data to TENNCARE and TENNCARE's authority to collect, maintain, use and share data with CONTRACTOR is protected under federal law for specified purposes:
- 5.40.8.1.1 Sections 1137, 453, and 1106(b) of the Social Security Act (the Act) (42 U.S.C. §§ 1320b-7, 653, and 1306(b)) (income and eligibility verification data);
- 5.40.8.1.2 26 U.S.C. § 6103(l)(7) and (8) (tax return. data);
- 5.40.8.1.3 Section 202(x)(3)(B)(iv) of the Act (42 U.S.C. § 401(x)(3)(B)(iv))(prisoner data);
- 5.40.8.1.4 Section 205(r)(3) of the Act (42, U.S.C. § 405(r)(3)) and Intelligence Reform and Terrorism Prevention Act of 2004, Pub. L. 108-458, 7213(a)(2) (death data);
- 5.40.8.1.5 Sections 402, 412, 421, and 435 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Pub. L. 104-193) (8 U.S.C. §§ 1612, 1622, 1631, and 1645) (August 22, 1996 (quarters of coverage data);
- 5.40.8.1.6 Children's Health Insurance Program Reauthorization Act of 2009, (Pub. L. 111-3) (February 4, 2009) (citizenship data); and
- 5.40.8.1.7 Routine use exception to the Privacy Act, 5 U.S.C. § 552a(b)(3)(data necessary to administer other programs compatible with SSA programs).
- 5.40.8.2 This Section further carries out Section 1106(a) of the Act (42 U.S.C. § 1306), the regulations promulgated pursuant to that section (20 C.F.R. Part 401), the Privacy of 1974 (5 U.S.C. § 552a), as amended by the Computer Matching and Privacy Protection Act of 1988, related Office of Management and Budget ("OMB") guidelines, the Federal Information Security Management Act of 2002 ("FISMA") (44 U.S.C. § 3541 *et seq.*), and related National Institute of Standards and Technology ("NIST") guidelines, which provide the requirements that the CONTRACTOR must follow with regard to use, treatment, and safeguarding data.

Amendment 28 (cont.)

5.40.9 Definitions

- 5.40.9.1 “SSA-supplied data” – information, such as an individual’s social security number, supplied by the Social Security Administration to TENNCARE to determine entitlement or eligibility for federally-funded programs (Computer Matching and Privacy Protection Contract between SSA and F&A; IEA between SSA and TENNCARE).
- 5.40.9.2 “Protected Health Information/Personally Identifiable Information” (PHI/PII) (45 CFR §160.103; OMB Circular M-06-19 located at <http://www.whitehouse.gov/sites/default/files/omb/memoranda/fy2006/m06-19.pdf>) – Protected health information means individually identifiable health information that is: (i) Transmitted by electronic media; (ii) Maintained in electronic media; or (iii) Transmitted or maintained in any other form or medium.
- 5.40.9.3 “Individually Identifiable Health Information” – information that is a subset of health information, including demographic information collected from an individual, and: (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) identifies the individual; or (ii) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
- 5.40.9.4 “Personally Identifiable Information” – any information about an individual maintained by an agency, including, but not limited to, education, financial transactions, medical history, and criminal or employment history and information which can be used to distinguish or trace an individual's identity, such as their name, Social Security Number, date and place of birth, mother's maiden name, biometric records, including any other personal information which can be linked to an individual.

70. **Attachment VI shall be amended by adding “TBI MFCU” in the “TO:” section along with “Office of Program Integrity”.**
71. **Exhibits C, E, F, I, J and L of Attachment IX shall be deleted and replaced with “LEFT BLANK INTENTIONALLY”.**

Amendment 28 (cont.)

All of the provisions of the original Agreement not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective July 1, 2012.

The CONTRACTOR, by signature of this Amendment, hereby affirms that this Amendment has not been altered and therefore represents the identical document that was sent to the CONTRACTOR by TENNCARE.

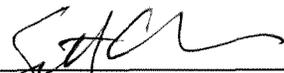
IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

BY: 
Mark Emkes
Commissioner

DATE: 6/14/12

**VOLUNTEER STATE HEALTH PLAN,
INC.**

BY: 
Scott C. Pierce
President & CEO VSHP

DATE: 6/2/12

CONTRACT SUMMARY SHEET



RFS Number:	31866-00026	EDISON ID 29635	Contract Number:	FA-02-14632-27
State Agency:	Department of Finance and Administration		Division:	Bureau of TennCare

Contractor	Contract Identification Number
VSHP (TennCare Select)	<input type="checkbox"/> V- <input type="checkbox"/> C-

Service Description

Managed Care Organization / Medically Necessary Health Care Services to the TennCare/Medicaid Population

Contract Begin Date	Contract End Date
7/1/2001	6/30/2013

Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66	4A2	134	11	<input type="checkbox"/> STARS		
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)	
2002	\$6,755,937.23	\$11,843,931.25			\$18,599,868.48	
2003	\$15,785,123.40	\$17,294,819.40			\$33,079,942.80	
2004	\$25,125,990.72	\$38,364,165.90			\$63,490,156.62	
2005	\$58,007,447.00	\$58,007,447.00			\$116,014,894.00	
2006	\$87,748,111.00	\$87,748,111.00			\$175,496,222.00	
2007	\$87,748,111.00	\$87,748,111.00			\$175,496,222.00	
2008	\$72,610,000.00	\$127,390,000.00			\$200,000,000.00	
2009	\$72,610,000.00	\$127,390,000.00			\$200,000,000.00	
2010	\$100,882,479.00	\$304,024,121.00			\$404,906,600.00	
2011	\$131,085,619.00	\$312,820,981.00			\$443,906,600.00	
2012	\$149,893,942.00	\$294,012,658.00			\$443,906,600.00	
2013	\$150,102,578.00	\$293,804,022.00			\$443,906,600.00	
Total:	\$958,355,338.35	\$1,760,448,367.55			\$2,718,803,705.90	

CFDA# 93.778 Title XIX Dept. of Health & Human Svcs.	Check the box ONLY if the answer is YES:
State Fiscal Contract	Is the Contractor a SUBRECIPIENT? (per OMB A-133)
Name: Casey Dungan	Is the Contractor a Vendor? (per OMB A-133)
Address: 310 Great Circle Road Nashville, TN	Is the Fiscal Year Funding STRICTLY LIMITED?
Phone: (615)507-6482	Is the Contractor on STARS?
Procuring Agency Budget Officer Approval Signature	Is the Contractor's FORM W-9 ATTACHED?
Casey Dungan	Is the Contractor's Form W-9 Filed with Accounts?

COMPLETE FOR ALL AMENDMENTS (only)			Funding Certification
CONTRACT END DATE:	Base Contract & Prior Amendments	This Amendment ONLY	Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.
Y: 2002	\$18,599,868.48		
Y: 2003	\$33,079,942.80		
Y: 2004	\$63,490,156.62		
Y: 2005	\$116,014,894.00		
Y: 2006	\$175,496,222.00		
Y: 2007	\$175,496,222.00		
Y: 2008	\$200,000,000.00		
Y: 2009	\$200,000,000.00		
Y: 2010	\$404,906,600.00		
Y: 2011	\$443,906,600.00		
Y: 2012	\$443,906,600.00		
Y: 2013		\$443,906,600.00	
Total:	\$2,274,897,105.90	\$443,906,600.00	

AMENDMENT NUMBER 27
AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.

CONTRACT NUMBER: FA-02-14632-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as specified below.

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. Section 1 shall be amended by deleting and replacing the following definitions:

Immediate Eligibility for CHOICES Group 2 – A mechanism by which the State can, based on a preliminary determination of a person’s eligibility for the CHOICES 217-Like HCBS Group, enroll the person into CHOICES Group 2 and provide immediate access to a limited package of CHOICES HCBS pending a final determination of eligibility. To qualify for immediate eligibility, a person must be applying to receive covered ongoing CHOICES HCBS, be determined by TENNCARE to meet nursing facility level of care, have submitted an application for financial eligibility determination to DHS, and be expected to qualify for CHOICES Group 2 based on review of the financial information provided by the applicant. Immediate eligibility shall only be for specified CHOICES HCBS (no other covered services) and for a maximum of forty-five (45) days from the effective date of eligibility.

Immediate Eligibility – Temporary eligibility granted to a child upon entering into State custody in order to give children in State custody adequate access to medical and behavioral health services, including TENNderCare, until a final determination can be made on their TennCare eligibility.

2. Section 1 shall be amended by adding the following definitions:

Abuse - Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program (see 42 CFR 455.2).

Breach (with respect to Protected Health Information (PHI)) - The acquisition, access, use, or disclosure of protected health information in a manner not permitted under the HIPAA Privacy Rule which compromises the security or privacy of the protected health information.

Fraud – An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act

Amendment Number 27 (cont.)

that constitutes fraud under applicable Federal or State law (see 42 CFR 455.2).

Repayment – The process by which an MCO, the State of Tennessee or the Federal government, or any of their Bureaus, Agencies or Contractors recover Title XIX monies paid to an MCO, provider or enrollee.

3. Section 2.4.6.2 and 2.4.6.3 shall be deleted and replaced as follows:

2.4.6.2 The CONTRACTOR agrees to accept daily eligibility updates in the form and format specified by TennCare for the purpose of identifying children in State custody and children transitioning out of State custody. Until such time as an indicator for children in State custody and children transitioning out of State custody can be added to the daily eligibility updates received from TennCare, the CONTRACTOR agrees to accept and process any adhoc report mutually agreed upon by the CONTRACTOR and TennCare to facilitate timely identification of children in State custody or children transitioning out of State custody.

2.4.6.3 The CONTRACTOR shall provide an electronic inbound 834 eligibility file to TENNCARE as specified and in conformance to data exchange format and method standards outlined in Section 2.23.5.

4. Section 2.6.1.5.1 shall be deleted and replaced as follows:

2.6.1.5.1 In addition to physical health benefits (see Section 2.6.1.3) and behavioral health benefits (see Section 2.6.1.4), the CONTRACTOR shall provide long-term care services (including CHOICES HCBS and nursing facility care) as described in this Section 2.6.1.5 to members who have been enrolled into CHOICES by TENNCARE, as shown in the outbound 834 enrollment file furnished by TENNCARE to the CONTRACTOR, effective upon the CHOICES Implementation Date (see Section 1). Unless and until directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, only members in CHOICES Group 1 will be enrolled with the CONTRACTOR. Therefore, unless and until directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the requirements in Section 2.6.1.5 applicable only to CHOICES Group 2 and/or 3 will not apply. When directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the CONTRACTOR shall, as directed by TENNCARE, comply with all of the requirements in Section 2.6.1.5.

5. Section 2.7.4.1 shall be deleted and replaced as follows:

2.7.4.1 The CONTRACTOR shall develop programs and participate in activities to enhance the general health and well-being of members. Health education and outreach programs and activities shall include TENNderCare outreach activities (See Section 2.7.6.2) and may also include the following:

6. Section 2.7.4.2 shall be deleted and replaced by Sections 2.7.4.2 through 2.7.4.2.3 as follows:

2.7.4.2 The CONTRACTOR shall submit an Annual Community Outreach Plan no later than November 30 of each year for review and approval by TENNCARE.

2.7.4.2.1 The Annual Community Outreach Plan shall be written in accordance with guidance prepared by TENNCARE. It shall include, but is not limited to: all proposed community/health

Amendment Number 27 (cont.)

education events related to TENNderCare; community/health education events unrelated to TENNderCare; rationale for participating in these events; and a process for evaluating the benefits of the events.

2.7.4.2.2 The CONTRACTOR's TennCare approved Annual Community Outreach Plan shall be implemented on January 1 of each year.

2.7.4.2.3 Community/health education events, both related and unrelated to TENNderCare, shall be included in the quarterly TENNderCare Report (See Section 2.30.4.4) in a format specified by TENNCARE.

7. Section 2.7.6.2.10 shall be amended by adding the reference “(See Section 2.7.4.2)” to the end of the first sentence.

8. ~~Section 2.9.2.1.4 shall be deleted and replaced as follows:~~

~~2.9.2.1.4 For covered long-term care services for CHOICES members who are transferring from another MCO, the CONTRACTOR shall be responsible for continuing to provide covered long-term care services, including both CHOICES HCBS authorized by the transferring MCO and nursing facility services, without regard to whether such services are being provided by contract or non-contract providers. Unless and until the CONTRACTOR has been directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, only members in CHOICES Group 1 will be enrolled with the CONTRACTOR. Therefore, unless and until directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the requirements in this Section 2.9.2.1.4 applicable only to CHOICES Group 2 and/or 3 will not apply. When directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the CONTRACTOR shall, as directed by TENNCARE, comply with all of the requirements in Section 2.9.2.1.4.~~

9. Section 2.9.5.4.1 through 2.9.5.4.1.4 shall be deleted and replaced as follows:

2.9.5.4.1 In addition to requirements pertaining to nursing facility to community transitions (see Section 2.9.6.8), members in CHOICES Group 1 who are under the age of 21 and who are residents of a nursing facility and have requested to transition home will be provided coordination of care by the CHOICES Care Coordinator and MCO Case Management staff:

2.9.5.4.1.1 The member will be informed by the CHOICES Care Coordinator of disenrollment from CHOICES upon discharge from Nursing Facility;

2.9.5.4.1.2 Within three (3) business days of a request to transition by or on behalf of a Group 1 member under age 21, the member will be referred by the CHOICES Care Coordinator to MCO Case Management for service identification and implementation in the home setting;

2.9.5.4.1.3 The MCO Case Manager will be responsible for developing a service plan for the home setting;

2.9.5.4.1.4 The CHOICES Care Coordinator will communicate weekly via phone or face-to-face visits with the MCO Case Management staff, the member and/or his parent or guardian

(as applicable and appropriate), and the nursing facility staff to ensure timely progression of the transition plan until the transition plan is complete; and

10. Section 2.9.6.1.6.1 shall be amended by adding a “)” after the word “computation”.

11. Sections 2.9.6.8.1 shall be amended by adding the following lead in text:

2.9.6.8.1 As applicable, including when directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the CONTRACTOR shall develop and implement methods for identifying members who may have the ability and/or desire to transition from a nursing facility to the community. Such methods shall include, at a minimum:

12. Section 2.9.6.2.5.1 shall be deleted and replaced as follows:

2.9.6.2.5.1 For members enrolled in CHOICES Group 2 who are, upon CHOICES enrollment, receiving community-based residential alternative services that are covered in CHOICES, the CONTRACTOR shall, immediately upon notice of the member’s enrollment in CHOICES, authorize such services from the current provider as of the effective date of CHOICES enrollment. In the case of those members enrolled in CHOICES Group 2 on the basis of Immediate Eligibility for CHOICES Group 2, community-based residential alternative services shall be authorized immediately upon notice of the member’s categorical and financial eligibility for TennCare CHOICES as of the effective date of CHOICES enrollment. The CONTRACTOR shall not transition members enrolled in CHOICES Group 2 who are, upon CHOICES enrollment, receiving services in a community-based residential alternative setting to another facility unless: (1) the member or his/her representative specifically requests to move, which shall be documented in the member’s file; (2) the member or his/her representative provides written consent to move based on quality or other concerns raised by the CONTRACTOR; or (3) the facility where the member is residing is not a contract provider; if the facility is a non-contract provider, the CONTRACTOR shall authorize medically necessary services from the non-contract provider for at least thirty (30) days which shall be extended as necessary to ensure continuity of care pending the facility’s enrollment with the CONTRACTOR or the member’s transition to a contract provider.

13. Section 2.9.6.3.7 shall be deleted and replaced as follows:

2.9.6.3.7 If the member does not meet the telephone screening criteria, the CONTRACTOR shall within five (5) business days of the screening notify the member verbally and in writing in the format prescribed by TENNCARE: (1) that he/she does not appear to meet the criteria for enrollment in CHOICES; (2) that he/she has the right to continue with the CHOICES intake process and, if determined not eligible, to receive notice of such denial, including the member’s due process right to appeal; and (3) how, if the member wishes to proceed with the CHOICES intake process, the member can submit a written request to proceed with the CHOICES intake process to the CONTRACTOR. In the event that a member does submit such written request, the CONTRACTOR shall process the request as a new referral and shall conduct a face-to-face intake visit, including level of care assessment and needs assessment, within ten (10) business days of receipt of the member’s written request, unless a later date is requested by the member, which shall be documented in writing in the CHOICES intake record.

14. Section 2.9.6.6.1.1 shall be amended by adding the word “CHOICES” in front of the word “file”.

15. Section 2.9.6.6.2.7 shall be deleted and replaced as follows:

2.9.6.6.2.7 The member’s care coordinator/care coordination team shall provide a copy of the member’s completed plan of care, including any updates, to the member, the member’s representative, as applicable, and the member’s community residential alternative provider, as applicable. The member’s care coordinator/care coordination team shall provide copies to other providers authorized to deliver care to the member upon request, and shall ensure that such providers who do not receive a copy of the plan of care are informed in writing prior to the scheduled implementation of services of all relevant information needed to ensure the provision of quality care for the member and to help ensure the member’s health, safety, and welfare, including but not limited to the tasks and functions to be performed.

16. Section 2.9.6.6.2.8 shall be amended by adding a new Section 2.9.6.6.2.8.1 which shall read as follows:

2.9.6.6.2.8.1 Within three (3) business days of updating the member’s plan of care, the member’s care coordinator/care coordination team shall provide a copy of all relevant changes to the supports broker, as applicable, and to other providers authorized to deliver care to the member. Relevant information shall include any information needed to ensure the provision of quality care for the member and to help ensure the member’s health, safety, and welfare, including but not limited to any changes in the tasks and functions to be performed.

17. Section 2.9.6.8.25.3 and Section 2.9.6.8.25.4 shall be deleted and replaced by new Sections 2.9.6.8.25.3, 2.9.6.8.25.4 and 2.9.6.8.25.4.1 as follows:

2.9.6.8.25.3 The CONTRACTOR shall conduct a census at least semi-annually at no less than one hundred twenty (120)-day intervals or as frequently as deemed necessary by TENNCARE to confirm the residency status and Group assignment of all CHOICES members (i.e., Group 1 receiving services in a NF or Group 2 receiving HCBS or short-term NF services). The CONTRACTOR shall take actions as necessary to address any discrepancies when a CHOICES member is found to no longer be receiving LTC services, or is receiving services in a different service delivery setting, e.g., NF, HCBS, or hospice in a NF, including, as appropriate, disenrollment from CHOICES and/or enrollment in a different CHOICES Group.

2.9.6.8.25.4 The CONTRACTOR shall authorize and/or reimburse short-term NF stays for Group 2 members only when the member’s stay in the facility is expected to be less than ninety (90) days and the member is expected to return to the community upon its conclusion. The CONTRACTOR shall monitor all short-term NF stays for Group 2 members and shall ensure that the member is transitioned from Group 2 to Group 1 at any time a) it is determined that the stay will not be short-term or the member will not transition back to the community; and b) prior to exhausting the ninety (90)-day short-term NF benefit covered for CHOICES Group 2 members.

2.9.6.8.25.4.1 Upon request, the CONTRACTOR shall provide to TENNCARE a member-by-member status for each Group 2 member utilizing the short-term NF stay benefit, including but not limited to the name of each Group 2 member receiving short-term NF services, the NF in which s/he currently resides, the date of admission for short-term stay, and the anticipated date of discharge back to the community.

18. Section 2.9.6.9.1.1.4 shall be amended by deleting the word “and” at the end of the text and Section 2.9.6.9.1.1.5 shall be deleted and replaced as follows:

2.9.6.9.1.1.5 In the manner prescribed by TENNCARE and in accordance with this Agreement and TENNCARE policies and protocols pertaining thereto: 1) facilitate transfers between nursing facilities which, at a minimum, includes notification to the receiving facility of the member’s level of care, and notification to DHS; and 2) facilitate transitions to CHOICES Group 2 which shall include (but is not limited to) timely notification to TENNCARE; and

19. Section 2.9.6.9.2.1.2 shall be deleted and replaced as follows:

2.9.6.9.2.1.2 During the development of the member’s plan of care and as part of the annual updates, the care coordinator shall discuss with the member his/her interest in consumer direction when eligible CHOICES HCBS are included in the plan of care;

20. Section 2.9.6.9.2.1.15 shall be amended by deleting the word “and” at the end of the text, Section 2.9.6.9.2.1.17 shall be amended by deleting the “.” and adding “; and”, and Section 2.9.6.9.2.1 shall be amended by adding a new Section 2.9.6.9.2.1.18 as follows:

2.9.6.9.2.1.18 In the manner prescribed by TENNCARE, and in accordance with this Agreement and TENNCARE policies and protocols pertaining thereto, facilitate transition to CHOICES Group 1, which shall include (but is not limited to) timely notification to TENNCARE.

21. Section 2.9.6.10.1 shall be amended by adding new text to the end as follows:

2.9.6.10.1 In addition to the roles and responsibilities otherwise specified in this Section 2.9.6, the CONTRACTOR shall ensure that the following additional care coordination functions related to consumer direction of eligible CHOICES HCBS are fulfilled. As provided in Section 2.9.7, only members in CHOICES Group 2 or 3 may participate in consumer direction of HCBS. Therefore, requirements regarding consumer direction of HCBS will not apply to the CONTRACTOR unless and until the CONTRACTOR is directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3. When directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the CONTRACTOR shall, as directed by TENNCARE, comply with all the requirements in Section 2.9.6.10.

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22. Section 2.9.6.10.3 shall be deleted and replaced by new Sections 2.9.6.10.3 through 2.9.6.3.10.3.3 as follows:

2.9.6.10.3 If a member elects not to receive eligible CHOICES HCBS using contract providers until all necessary requirements have been fulfilled in order to implement consumer direction of eligible CHOICES HCBS:

2.9.6.10.3.1 The CONTRACTOR shall document this decision, including date and member/member's representative's signature, in the manner specified by TENNCARE (see Section 2.9.7.4.3.2 of this Agreement).

2.9.6.10.3.2 The member's care coordinator shall visit the member face to face at least monthly to ensure that the member's needs are met, and shall continue to offer eligible CHOICES HCBS through contract providers (See Section 2.9.7.4.3.3).

2.9.6.10.3.3 If eligible CHOICES HCBS are not initiated within sixty (60) days following referral to the FEA, the CONTRACTOR shall notify the member that eligible CHOICES HCBS must be initiated by contract providers unless these HCBS are not needed on an ongoing basis in order to safely meet the member's needs in the community, in which case, the CONTRACTOR shall submit documentation to TENNCARE to begin the process of disenrollment from CHOICES Group 2.

23. Section 2.9.6.10 shall be amended by adding a new Section 2.9.6.10.11 as follows and renumbering the remaining Section accordingly, including any references thereto.

2.9.6.10.11 Within three (3) business days of updating the member's plan of care, the member's care coordinator/care coordination team shall provide a copy of all relevant changes to the supports broker (see Section 2.9.6.6.2.8.1. of this Agreement).

24. Section 2.9.6.11.3 through 2.9.6.11.5 shall be deleted and replaced as follows and the remaining Section shall be renumbered accordingly, including any references thereto.

2.9.6.11.3 The CONTRACTOR shall ensure that an adequate number of care coordinators are available and that sufficient staffing ratios are maintained to address the needs of CHOICES members and meet all the requirements described in this Agreement.

2.9.6.11.4 The recommended average weighted care coordinator-to-CHOICES member staffing ratio is no more than 1:125. Such average shall be derived by dividing the total number of full-time equivalent care coordinators by the total weighted value of CHOICES members as delineated below.

2.9.6.11.5 The recommended maximum caseload for any individual care coordinator is a weighted value of no more than one hundred seventy-five (175) CHOICES members.

2.9.6.11.6 The contractor shall use the following methodology to calculate weighted care coordinator-to-CHOICES member staffing ratios and care coordinator caseloads:

2.9.6.11.6.1 Each CHOICES Group 1 member shall be factored into the weighted care coordinator-to-CHOICES member staffing ratio and weighted caseload calculations utilizing an acuity level of one (1), EXCEPT that:

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- 2.9.6.11.6.1.1 Upon completion of a Transition Assessment which indicates that a Group 1 member is a candidate for transition to the community, such member shall be factored into the weighted caseload and staffing ratio calculations using an acuity level of two and one-half (2.5) until such time as the member is transitioned to CHOICES Group 2 or the member is no longer a candidate for transition;
- 2.9.6.11.6.1.2 CHOICES Group 1 members under twenty-one (21) years of age shall be factored into the weighted caseload and staffing ratio calculations utilizing an acuity level of two and one-half (2.5).
- 2.9.6.11.6.2 Each CHOICES Group 2 member shall be factored into the weighted caseload and staffing ratio calculations utilizing an acuity level of two and one-half (2.5);
- 2.9.6.11.6.3 Using the delineated acuity factors, the following provides examples of the composition of caseloads with a weighted value of 125:

Weighted Caseload Mix for a 1:125 Ratio		
CH1 (Acuity 1.0)	CH 2 (Acuity 2.5)	Total CHOICES Members on Caseload
125	0	125
100	10	110
75	20	95
50	30	80
25	40	65
0	50	50

- 2.9.6.11.6.4 Using the delineated acuity factors, the following delineates the composition of caseloads with a weighted value of 175:

Weighted Caseload Mix for a 1:175 Ratio		
CH1 (Acuity 1.0)	CH 2 (Acuity 2.5)	Total CHOICES Members on Caseload
175	0	175
150	10	160
125	20	145
100	30	130
75	40	115
50	50	100
25	60	85
0	70	70

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- 2.9.6.11.7 The CONTRACTOR shall proactively plan for staff turnover and shall monitor caseload assignments and weighted care coordinator-to-CHOICES member staffing ratios and adjust hiring practices and care coordinator assignments as necessary to meet the requirements of this Agreement and to address members' needs.
- 2.9.6.11.8 Upon request, the CONTRACTOR shall provide to TENNCARE documentation of such monitoring, including an itemized list by care coordinator of the total number of members assigned, and the number of Group 1 members (including members in transition and children under age 21) and Group 2 members that comprise each care coordinator's caseload.
- 2.9.6.11.9 In the event that the CONTRACTOR is determined to be deficient with any requirement pertaining to care coordination as set forth in this agreement, the amount of financial sanctions assessed shall take into account whether or not the CONTRACTOR has complied with the recommended average weighted care coordinator to CHOICES member staffing ratio and the maximum weighted care coordinator caseload amounts set forth in Sections 2.9.6.11.4 and 2.9.6.11.5, based on the most recent monthly *CHOICES Caseload and Staffing Ratio Report* (see Section 2.30.6.8). All applicable sanctions set forth in Sections 5.20.2.2.6., 5.20.2.2.7.A.16, ~~5.20.2.2.7.A.18,~~ ~~5.20.2.2.7.A.19,~~ ~~5.20.2.2.7.A.20,~~ ~~5.20.2.2.7.A.21,~~ 5.20.2.2.7.A.22, 5.20.2.2.7.A.23, 5.20.2.2.7.A.28, 5.20.2.2.7.A.29, 5.20.2.2.7.A.30, 5.20.2.2.7.A.31, 5.20.2.2.7.B.21, and 5.20.2.2.7.C.7 of this agreement shall be multiplied by two (2) when the CONTRACTOR has not complied with these recommendations.
- 2.9.6.11.10 TennCare will reevaluate Care Coordinator-to-CHOICES member staffing ratio recommendations and requirements on at least an annual basis and may make adjustments based on the needs of CHOICES members, CHOICES program requirements and MCO performance.
- 2.9.6.11.11 TENNCARE may request changes in the CONTRACTOR's Care Coordination Staffing Plan at any time it determines that the CONTRACTOR does not have sufficient care coordination staff to properly and timely perform its obligations under this Agreement.

25. The renumbered Section 2.9.6.11.18 shall be deleted and replaced as follows:

- 2.9.6.11.18 The CONTRACTOR shall provide initial training to newly hired care coordinators and ongoing training to care coordinators. Unless and until directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, training shall focus on the requirements applicable to CHOICES Group 1. When directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the CONTRACTOR shall, as directed by TENNCARE, train care coordinators on requirements applicable to CHOICES Group 2 and/or 3. Initial training topics shall include at a minimum:

26. Section 2.9.6.11 shall be amended by adding a new Section 2.9.6.11.19 as follows and renumbering the remaining Section including any references thereto.

- 2.9.6.11.19 The CONTRACTOR shall establish an ongoing training program for care coordinators. Topics to be covered shall be determined by the CONTRACTOR based on its monitoring of care coordination (see Section 2.9.6.12) and the CHOICES program, and feedback from TENNCARE.

27. Section 2.9.6.12.7 shall be amended by adding the words “and document” as follows:

2.9.6.12.7 The CONTRACTOR shall develop and maintain an electronic case management system that includes the functionality to ensure and document compliance with all requirements specified in the Section 1115 TennCare Demonstration Waiver, federal and state laws and regulations, this Agreement, and TennCare policies and protocols, including but not limited to the following:

28. Section 2.9.7.1.1 shall be amended by adding language as follows:

2.9.7.1.1 Requirements regarding consumer direction of HCBS will not apply to the CONTRACTOR unless and until the CONTRACTOR is directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3. If directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the CONTRACTOR shall offer consumer direction of eligible CHOICES HCBS to all CHOICES Group 2 and 3 members who are determined by a care coordinator, through the needs assessment/reassessment process, to need attendant care, personal care, homemaker, in-home respite, companion care services and/or any other service specified in TennCare rules and regulations as available for consumer direction. (Companion care is only available for persons electing consumer direction of eligible CHOICES HCBS.) A service that is not specified in TennCare rules and regulations as available for consumer direction or that is not a CHOICES HCBS shall not be consumer directed. Consumer direction in CHOICES affords members the opportunity to have choice and control over how eligible CHOICES HCBS are provided, who provides the services and how much workers are paid for providing care, up to a specified maximum amount established by TENNCARE (see Section 2.9.7.6.11). Member participation in consumer direction of eligible CHOICES HCBS is voluntary. Members may elect to participate in or withdraw from consumer direction of eligible CHOICES HCBS at any time, service by service, without affecting their enrollment in CHOICES. To the extent possible, the member shall provide his/her care coordinator ten (10) days advance notice regarding his/her intent to no longer direct one or more eligible CHOICES HCBS or to withdraw from participation in consumer direction of eligible CHOICES HCBS entirely. The CONTRACTOR shall respond to the member’s request in keeping with the timeframes and processes set forth in this Section, in order to facilitate a seamless transition to appropriate service delivery. TENNCARE may establish reasonable limitations on the frequency with which members may opt into and out of consumer direction of eligible CHOICES HCBS.

29. Section 2.9.16.6 shall be deleted and replaced and Section 2.9.16.7 shall be deleted in its entirety and the remaining Section 2.9.16 shall be renumbered accordingly, including any references thereto.

2.9.16.6 Area Agencies on Aging and Disability (AAADs) regarding intake of members new to both TennCare and CHOICES, and assisting CHOICES members in Groups 2 and 3 with the TennCare eligibility redetermination process;

30. Section 2.12.9 shall be deleted and replaced as follows:

2.12.9 All provider agreements executed by the CONTRACTOR, and all provider agreements executed by subcontracting entities or organizations, shall, except as otherwise provided in Section 2.12.13, at a minimum, meet the following requirements:

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- 2.12.9.1 Be in writing. All new provider agreements and existing provider agreements as they are renewed, shall include a signature page which contains CONTRACTOR and provider names which are typed or legibly written, provider company with titles, and dated signatures of all appropriate parties;
- 2.12.9.2 Specify the effective dates of the provider agreement;
- 2.12.9.3 Specify that the provider agreement and its attachments contain all the terms and conditions agreed upon by the parties;
- 2.12.9.4 Assure that the provider shall not enter into any subsequent agreements or subcontracts for any of the work contemplated under the provider agreement without the prior written approval of the CONTRACTOR;
- 2.12.9.5 Identify the population covered by the provider agreement;
- 2.12.9.6 Specify that the provider may not refuse to provide covered medically necessary or covered preventive services to a child under the age of twenty-one (21) or a TennCare Medicaid patient under this Agreement for non-medical reasons. However, the provider shall not be required to accept or continue treatment of a patient with whom the provider feels he/she cannot establish and/or maintain a professional relationship;
- 2.12.9.7 Specify the functions and/or services to be provided by the provider and assure that the functions and/or services to be provided are within the scope of his/her professional/technical practice;
- 2.12.9.8 Specify the amount, duration and scope of services to be provided by the provider and inform the provider of TennCare non-covered services as described in Section 2.10 of this Agreement and the TennCare rules and regulations;
- 2.12.9.9 Provide that emergency services be rendered without the requirement of prior authorization of any kind;
- 2.12.9.10 Require compliance with applicable access requirements, including but not limited to appointment and wait times as referenced in Section 2.11 of the CONTRACTOR's Agreement with TENNCARE;
- 2.12.9.11 Specify that unreasonable delay in providing care to a pregnant member seeking prenatal care shall be considered a material breach of the provider's agreement with the CONTRACTOR and include the definition of unreasonable delay as described in Section 2.7.5.2.3 of this Agreement;
- 2.12.9.12 If the provider performs laboratory services, require the provider to meet all applicable requirements of the Clinical Laboratory Improvement Amendments (CLIA) of 1988;
- 2.12.9.13 Require the provider to have and maintain documentation necessary to demonstrate that covered services were provided in compliance with state and federal requirements;
- 2.12.9.14 Require that an adequate record system be maintained and that all records be maintained for five (5) years from the close of the provider agreement (behavioral health records shall be maintained at the provider level for ten (10) years after the termination of the provider agreement pursuant to TCA 33-3-101) or retained until all evaluations, audits, reviews or

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investigations or prosecutions are completed for recording enrollee services, servicing providers, charges, dates and all other commonly accepted information elements for services rendered to enrollees pursuant to the provider agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the provider agreement and administrative, civil or criminal investigations and prosecutions);

- 2.12.9.15 Include a statement that as a condition of participation in TennCare, enrollees and providers shall give TENNCARE or its authorized representative, the Office of the Comptroller of the Treasury, and any health oversight agency, such as OIG, TBI MFCU, DHHS Office of Inspector General (DHHS OIG), and DOJ, and any other authorized state or federal agency, access to their records. Said records shall be made available and furnished immediately upon request by the provider for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring as well as for administrative, civil and criminal investigations or prosecutions upon the request of an authorized representative of the CONTRACTOR, TENNCARE or authorized federal, state and Office of the Comptroller of the Treasury personnel, including, but not limited to, the OIG, the TBI MFCU, the DHHS OIG and the DOJ;
- 2.12.9.16 Include medical records requirements found in Section 2.24.6 of this Agreement;
- 2.12.9.17 Contain the language described in Section 2.25.6 of this Agreement regarding Audit Requirements and Section 2.25.5 of this Agreement regarding Availability of Records;
- 2.12.9.18 Provide that TENNCARE, DHHS OIG, Office of the Comptroller of the Treasury, OIG, TBI MFCU, and DOJ, as well as any authorized state or federal agency or entity shall have the right to evaluate through inspection, evaluation, review or request, whether announced or unannounced, or other means any records pertinent to this Agreement including, but not limited to medical records, billing records, financial records, and/or any records related to services rendered, quality, appropriateness and timeliness of services and/or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution and such evaluation, inspection, review or request, and when performed or requested, shall be performed with the immediate cooperation of the provider. Upon request, the provider shall assist in such reviews including the provision of complete copies of medical records. Include a statement that HIPAA does not bar disclosure of protected health information (PHI) to health oversight agencies, including, but not limited to, OIG, TBI MFCU, DHHS OIG and DOJ. Provide that any authorized state or federal agency or entity, including, but not limited to TENNCARE, OIG, TBI MFCU, DHHS OIG, DOJ, Office of the Comptroller of the Treasury, may use these records and information for administrative, civil or criminal investigations and prosecutions;
- 2.12.9.19 Provide for monitoring, whether announced or unannounced, of services rendered to members;
- 2.12.9.20 Provide for the participation and cooperation in any internal and external QM/QI, monitoring, utilization review, peer review and/or appeal procedures established by the CONTRACTOR and/or TENNCARE;
- 2.12.9.21 Specify CONTRACTOR's responsibilities under this Agreement and its agreement with the provider, including but not limited to, provision of a copy of the member handbook and provider handbook whether via web site or otherwise and requirement that the CONTRACTOR notice a provider of denied authorizations;

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- 2.12.9.22 Specify that the CONTRACTOR shall monitor the quality of services delivered under the provider agreement and initiate corrective action where necessary to improve quality of care, in accordance with that level of medical, behavioral health, or long-term care which is recognized as acceptable professional practice in the respective community in which the provider practices and/or the standards established by TENNCARE;
- 2.12.9.23 Require that the provider comply with corrective action plans initiated by the CONTRACTOR;
- 2.12.9.24 Provide for the timely submission of all reports and clinical information required by the CONTRACTOR;
- 2.12.9.25 Provide the name and address of the official payee to whom payment shall be made;
- 2.12.9.26 Make full disclosure of the method and amount of compensation or other consideration to be received from the CONTRACTOR. However, the agreement shall not include rate methodology that provides for an automatic increase in rates;
- 2.12.9.27 Specify that the CONTRACTOR shall only pay providers for services (1) provided in accordance with the requirements of this Agreement, the CONTRACTOR's policies and procedures implementing this Agreement, and state and federal law and (2) provided to TennCare enrollees who are enrolled with the CONTRACTOR; and specify that the provider is responsible for (1) ensuring that any applicable authorization requirements are met and (2) verifying that a person is eligible for TennCare on the date of service;
- 2.12.9.28 Provide for prompt submission of information needed to make payment. Specify that a provider shall have one hundred twenty (120) calendar days from the date of rendering a covered service to file a claim with the CONTRACTOR except in situations regarding coordination of benefits or subrogation in which case the provider is pursuing payment from a third party or if an enrollee is enrolled in the MCO with a retroactive eligibility date. In situations of third party benefits, the maximum time frames for filing a claim shall begin on the date that the third party documented resolution of the claim. In situations of enrollment in the CONTRACTOR's MCO with a retroactive eligibility date, the time frames for filing a claim shall begin on the date that the CONTRACTOR receives notification from TENNCARE of the enrollee's eligibility/enrollment;
- 2.12.9.29 Provide for payment to the provider upon receipt of a clean claim properly submitted by the provider within the required time frames as specified in TCA 56-32-126 and Section 2.22.4 of this Agreement;
- 2.12.9.30 Specify the provider shall accept payment or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payer) plus the amount of any applicable TennCare cost sharing responsibilities, as payment in full for covered services provided and shall not solicit or accept any surety or guarantee of payment from the enrollee in excess of the amount of applicable TennCare cost sharing responsibilities. Enrollee shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the enrollee being served;
- 2.12.9.31 Specify that in the event that TENNCARE deems the CONTRACTOR unable to timely process and reimburse claims and requires the CONTRACTOR to submit provider claims for reimbursement to an alternate claims processor to ensure timely reimbursement, the provider

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shall agree to accept reimbursement at the CONTRACTOR's contracted reimbursement rate or the rate established by TENNCARE, whichever is greater;

- 2.12.9.32 Specify the provider's responsibilities and prohibited activities regarding cost sharing as provided in Section 2.6.7 of this Agreement;
- 2.12.9.33 Specify the provider's responsibilities regarding third party liability (TPL), including the provider's obligation to identify third party liability coverage, including Medicare and long-term care insurance as applicable, and, except as otherwise provided in the CONTRACTOR's Agreement with TENNCARE, to seek such third party liability payment before submitting claims to the CONTRACTOR;
- 2.12.9.34 For those agreements where the provider is compensated via a capitation arrangement, language which requires:
 - ~~2.12.9.34.1 That if a provider becomes aware for any reason that he or she is not entitled to a capitation payment for a particular enrollee (a patient dies, for example), the provider shall immediately notify both the CONTRACTOR and TENNCARE by certified mail, return receipt requested; and~~
 - 2.12.9.34.2 The provider shall submit utilization or encounter data as specified by the CONTRACTOR so as to ensure the CONTRACTOR's ability to submit encounter data to TENNCARE that meets the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims;
- 2.12.9.35 Require the provider to comply with fraud and abuse requirements described in Section 2.20 of this Agreement;
- 2.12.9.36 Require that the provider comply with the Affordable Care Act and TennCare policy and procedures, including but not limited to, reporting overpayments and, when it is applicable, return overpayments to the CONTRACTOR within sixty (60) days from the date the overpayment is identified. Overpayments that are not returned within sixty (60) days from the date the overpayment was identified may result in a penalty pursuant to state or federal law;
- 2.12.9.37 Require the provider to comply and submit to the CONTRACTOR disclosure of information in accordance with the requirements, including timeframes, specified in 42 CFR Part 455, Subpart B and TennCare policies and procedures. The timeframes for this requirement shall include, at a minimum, at the time of initial contracting, contract renewal, at any time there is a change to any of the information on the disclosure form, at least once every three (3) years, and at anytime upon request;
- 2.12.9.38 Any reassignment of payment must be made in accordance with 42 CFR 447.10. All tax-reporting provider entities shall not be permitted to assign TennCare funds/payments to billing agents or alternative payees without executing a billing agent or alternative payee assignment agreement. The billing agents and alternative payees are subject to initial and monthly federal exclusion (LEIE) and debarment (EPLS) screening by the assignee if the alternative payee assignment is on-going. Further, direct and indirect payments to out of country individuals and/or entities are prohibited;
- 2.12.9.39 Require providers to screen their employees and contractors initially and on an ongoing monthly basis to determine whether any of them has been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section

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1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded or debarred. The provider shall be required to immediately report to the CONTRACTOR any exclusion information discovered. The provider shall be informed by the CONTRACTOR that civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to TennCare members;

- 2.12.9.40 The provider, subcontractor or any other entity agrees to abide by the Medicaid laws, regulations and program instructions that apply to the provider. The provider, subcontractor or any other entity understands that payment of a claim by TennCare or a TennCare Managed Care Contractor and/or Organization is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and is conditioned on the provider's, subcontractor's or any other entity's compliance with all applicable conditions of participation in Medicaid. The provider, subcontractor or any other entity understands and agrees that each claim the provider, subcontractor or any other entity submits to TennCare or a TennCare Managed Care Contractor and/or Organization constitutes a certification that the provider, subcontractor or any other entity has complied with all applicable Medicaid laws, regulations and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), in connection with such claims and the services provided therein;
- 2.12.9.41 Require the provider to conduct background checks in accordance with state law and TennCare policy;
- 2.12.9.42 Require the provider to report suspected abuse, neglect, and exploitation of adults in accordance with TCA 71-6-103 and to report suspected brutality, abuse, or neglect of children in accordance with TCA 37-1-403 and TCA 37-1-605;
- 2.12.9.43 Require that, for CHOICES members, the provider facilitate notification of the member's care coordinator by notifying the CONTRACTOR, in accordance with the CONTRACTOR's processes, as expeditiously as warranted by the member's circumstances, of any known significant changes in the member's condition or care, hospitalizations, or recommendations for additional services;
- 2.12.9.44 Require hospitals, including psychiatric hospitals, to cooperate with the CONTRACTOR in developing and implementing protocols as part of the CONTRACTOR's nursing facility diversion plan (see Section 2.9.6.7), which shall, include, at a minimum, the hospital's obligation to promptly notify the CONTRACTOR upon admission of an eligible member regardless of payor source for the hospitalization; how the hospital will identify members who may need home health, private duty nursing, nursing facility, or CHOICES HCBS upon discharge, and how the hospital will engage the CONTRACTOR in the discharge planning process to ensure that members receive the most appropriate and cost-effective medically necessary services upon discharge;
- 2.12.9.45 As a condition of reimbursement for global procedure codes for obstetric care, the provider shall submit utilization or encounter data as specified by the CONTRACTOR in a timely manner to support the individual services provided;

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- 2.12.9.46 Except as otherwise specified in Sections 2.12.11 or 2.12.12, require the provider to secure all necessary liability and malpractice insurance coverage as is necessary to adequately protect the CONTRACTOR's members and the CONTRACTOR under the provider agreement. The provider shall maintain such insurance coverage at all times during the provider agreement and upon execution of the provider agreement furnish the CONTRACTOR with written verification of the existence of such coverage;
- 2.12.9.47 Specify both the CONTRACTOR and the provider agree to recognize and abide by all state and federal laws, regulations and guidelines applicable to the CONTRACTOR and the provider. Provide that the agreement incorporates by reference all applicable federal law and state laws, TennCare rules and regulations, consent decrees or court orders, and revisions of such laws, regulations, consent decrees or court orders shall automatically be incorporated into the provider agreement, as they become effective;
- 2.12.9.48 Specify procedures and criteria for any alterations, variations, modifications, waivers, extension of the provider agreement termination date, or early termination of the agreement and specify the terms of such change. If provision does not require amendments be valid only when reduced to writing, duly signed and attached to the original of the provider agreement, then the terms shall include provisions allowing at least thirty (30) calendar days to give notice of rejection and requiring that receipt of notification of amendments be documented (e.g., certified mail, facsimile, hand-delivered receipt, etc);
- 2.12.9.49 Include provisions that allow the CONTRACTOR to suspend, deny, refuse to renew or terminate any provider agreement in accordance with the terms of the CONTRACTOR's Agreement with TENNCARE (see Section 5.4) and applicable law and regulation;
- 2.12.9.50 Specify that TENNCARE reserves the right to direct the CONTRACTOR to terminate or modify the provider agreement when TENNCARE determines it to be in the best interest of the State;
- 2.12.9.51 Specify that both parties recognize that in the event of termination of this Agreement between the CONTRACTOR and TENNCARE for any of the reasons described in Section 5.4 of this Agreement, the provider shall immediately make available, to TENNCARE, or its designated representative, in a usable form, any or all records, whether medical or financial, related to the provider's activities undertaken pursuant to the CONTRACTOR/provider agreement. The provision of such records shall be at no expense to TENNCARE;
- 2.12.9.52 Specify that the TennCare Provider Independent Review of Disputed Claims process shall be available to providers to resolve claims denied in whole or in part by the CONTRACTOR as provided at TCA 56-32-126(b);
- 2.12.9.53 Include a Conflict of Interest clause as stated in Section 5.19 of this Agreement, Gratuities clause as stated in Section 5.23 of this Agreement, and Lobbying clause as stated in Section 5.24 of this Agreement between the CONTRACTOR and TENNCARE;
- 2.12.9.54 Specify that at all times during the term of the agreement, the provider shall indemnify and hold TENNCARE harmless from all claims, losses, or suits relating to activities undertaken pursuant to the Agreement between TENNCARE and the CONTRACTOR. This indemnification may be accomplished by incorporating Section 5.31 of the TENNCARE/CONTRACTOR Agreement in its entirety in the provider agreement or by use of other language developed by the CONTRACTOR and approved in writing by TENNCARE;

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- 2.12.9.55 Require safeguarding of information about enrollees according to applicable state and federal laws and regulations and as described in Sections 2.27 and 5.33 of this Agreement;
- 2.12.9.56 Require the provider to comply with 42 CFR Part 438, Managed care, including but not limited to 438.6(f)(2)(i), compliance with the requirements mandating provider identification of provider-preventable conditions as a condition of payment. At a minimum, this shall mean non-payment of provider-preventable conditions as well as appropriate reporting as required by the CONTRACTOR and TENNCARE;
- 2.12.9.57 Specify provider actions to improve patient safety and quality;
- 2.12.9.58 Provide general and targeted education to providers regarding emergency appeals, including when an emergency appeal is appropriate, and procedures for providing written certification thereof, and specify that the provider shall comply with the appeal process, including but not limited to the following:
 - 2.12.9.58.1 Assist an enrollee by providing appeal forms and contact information including the appropriate address, telephone number and/or fax number for submitting appeals for state level review; and
 - 2.12.9.58.2 Require in advance, that providers seek prior authorization, when they feel they cannot order a drug on the TennCare PDL as well as taking the initiative to seek prior authorization or change or cancel the prescription when contacted by an enrollee or pharmacy regarding denial of a pharmacy service due to system edits (e.g., therapeutic duplication, etc.).
- 2.12.9.59 Require the provider to coordinate with the TennCare PBM regarding authorization and payment for pharmacy services;
- 2.12.9.60 Specify any liquidated damages, sanctions or reductions in payment that the CONTRACTOR may assess on the provider for specific failures to comply with contractual and/or credentialing requirements. This shall include, but may not be limited to a provider's failure or refusal to respond to the CONTRACTOR's request for information, the request to provide medical records, credentialing information, etc.; at the CONTRACTOR's discretion or a directive by TENNCARE, the CONTRACTOR shall impose financial consequences against the provider as appropriate;
- 2.12.9.61 Require that the provider display notices of the enrollee's right to appeal adverse action affecting services in public areas of their facility(s) in accordance with TennCare rules and regulations, subsequent amendments, or any and all consent decrees and court orders. The CONTRACTOR shall ensure that providers have a correct and adequate supply of public notices;
- 2.12.9.62 Include language which informs providers of the package of benefits that TENNderCare offers and which requires providers to make treatment decisions based upon children's individual medical and behavioral health needs. TENNderCare requirements are contained in Section 2.7.6 of this Agreement. All provider agreements shall contain language that references the TENNderCare requirements in this Agreement between TENNCARE and the CONTRACTOR, and the provider agreement shall either physically incorporate these sections of the Agreement or include language to require that these sections be furnished to the provider upon request;

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- 2.12.9.63 Include a provision which states that providers are not permitted to encourage or suggest, in any way, that TennCare children be placed into State custody in order to receive medical, behavioral, or long-term care services covered by TENNCARE;
 - 2.12.9.64 Require that providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees;
 - 2.12.9.65 Specify that the provider have written procedures for the provision of language interpretation and translation services for any enrollee who needs such services, including but not limited to, enrollees with Limited English Proficiency;
 - 2.12.9.66 The provider shall not use TennCare's name or trademark for any materials intended for dissemination to their patients unless said material has been submitted to TENNCARE by the CONTRACTOR for review and has been approved by TENNCARE in accordance with Section 2.17 of this Agreement. This prohibition shall not include references to whether or not the provider accepts TennCare; and
 - 2.12.9.67 Require that if any requirement in the provider agreement is determined by TENNCARE to conflict with the Agreement between TENNCARE and the CONTRACTOR, such requirement shall be null and void and all other provisions shall remain in full force and effect.
31. **Section 2.12.12.9 shall be amended by adding a new Section 2.12.12.9.3 which shall read as follows:**
- 2.12.12.9.3 Communicating with hospitals, discharge planners or other institutions for the purposes of soliciting potential CHOICES members that should instead be referred to the person's MCO or AAAD, as applicable;
32. **Section 2.12.12.10 shall be amended by deleting the word "and" at the end of the sentence.**
33. **Section 2.12.12 shall be amended by adding new Sections 2.12.12.12 and 2.12.12.13 as follows:**
- 2.12.12.12 Prohibit CHOICES providers from altering in any manner official CHOICES or MFP brochures or other CHOICES or MFP materials unless the CONTRACTOR has submitted a request to do so to TENNCARE and obtained prior written approval from TENNCARE in accordance with Section 2.17 of this Agreement; and
 - 2.12.12.13 Prohibit CHOICES providers from reproducing for its own use the CHOICES or MFP logos unless the CONTRACTOR has submitted a request to do so to TENNCARE and obtained prior written approval from TENNCARE in accordance with Section 2.17 of this Agreement.
34. **Section 2.13.1.2 shall be amended by deleting and replacing Section 2.13.1.2.6 and adding new Sections 2.13.1.2.7, 2.13.1.2.8 and 2.13.1.2.9 as follows and renumbering the remaining Section accordingly, including any references thereto.**
- 2.13.1.2.6 The CONTRACTOR shall ensure that payments are not issued to providers that have not obtained a Tennessee Medicaid provider number or for which disclosure requirements, as applicable, have not been obtained by the CONTRACTOR in accordance with 42 CFR

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455.100 through 106, Section 2.12.9. 37 of this Agreement, and TennCare policies and procedures.

2.13.1.2.7 The CONTRACTOR, as well as its subcontractors and tax-reporting provider entities shall not be permitted to assign TennCare funds/payments to billing agents or alternative payees without executing a billing agent or alternative payee assignment agreement. The billing agents and alternative payees are subject to initial and monthly federal exclusion (LEIE) and debarment (EPLS) screening by the assignee if the alternative payee assignment is on-going. Further, direct and indirect payments to out of country individuals and/or entities are prohibited.

2.13.1.2.8 For any entities to which the CONTRACTOR makes payment via electronic transfers, the CONTRACTOR shall have a signed EFT form that shall have 42 CFR 455.18 and 455.19 statements immediately preceding the "Signature" section.

~~2.13.1.2.9 The CONTRACTOR's failure to implement State Budget Reductions as described by TENNCARE may, at the discretion of TENNCARE, result in the CONTRACTOR forfeiting savings that would have been realized based on the timely implementation, including the forfeiture of recoupment from providers.~~

35. Section 2.14.1 shall be amended by deleting and replacing Section 2.14.1.1 and adding new Sections 2.14.1.2 through 2.14.1.4. The remaining Sections shall be renumbered accordingly, including any references thereto.

2.14.1.1 The CONTRACTOR shall develop and maintain a utilization management (UM) program which shall be documented in writing. As part of this program the CONTRACTOR shall have policies and procedures with defined structures and processes. The UM program shall assign responsibility to appropriate individuals including a designated senior physician and shall involve a designated behavioral health care practitioner in the implementation of behavioral health aspects of the program and a designated long-term care professional in the implementation of the long-term care aspects of the program.

2.14.1.2 The UM program shall be supported by an associated work plan and shall be evaluated annually and updated as necessary.

2.14.1.3 The UM program description, associated work plan, and annual evaluation of the UM program shall be submitted to TENNCARE (See Section 2.30.11.1).

2.14.1.4 The UM program, including the UM program description, associated work plan, and annual evaluation shall address Emergency Department (ED) utilization and ED diversion efforts.

36. The renumbered Section 2.14.1.16.1 shall be deleted and replaced as follows:

2.14.1.16.1 Review ED utilization data, at a minimum, every six (6) months to identify members with utilization exceeding the threshold defined by TENNCARE as ten (10) or more visits in the defined six (6) month period. The review due March 31st shall cover ED utilization during the preceding July through December; the review due September 30th shall cover ED utilization during the preceding January through June (See Section 2.30.11.7).

37. Section 2.15.6.1 shall be amended by adding a new Section 2.15.6.1.1 and 2.15.6.1.2 which shall read as follows:

- 2.15.6.1.1 Beginning with HEDIS 2012, the CONTRACTOR shall utilize the Hybrid methodology (i.e., gathered from administrative and medical record data) as the data collection method for any Medicaid HEDIS measure containing Hybrid Specifications as identified by NCQA.
- 2.15.6.1.2 The CONTRACTOR shall submit to TENNCARE by June 15 of each calendar year a detailed explanation for any Medicaid HEDIS measure marked as "Not Reported".

38. Section 2.15.7 shall be deleted and replaced as follows:

2.15.7 Critical Incident Reporting and Management

~~2.15.7.1 CHOICES Critical Incident Reporting and Management~~

~~2.15.7.1.1 The CONTRACTOR shall develop and implement a critical incident reporting and management system for incidents that occur in a home and community-based long-term care service delivery setting, including: community-based residential alternatives; adult day care centers; other CHOICES HCBS provider sites; and a member's home, if the incident is related to the provision of covered CHOICES HCBS.~~

~~2.15.7.1.2 The CONTRACTOR shall identify and track critical incidents and shall review and analyze critical incidents to identify and address potential and actual quality of care and/or health and safety issues. The CONTRACTOR shall regularly review the number and types of incidents (including, for example, the number and type of incidents across settings, providers, and provider types) and findings from investigations (including findings from APS and CPS if available); identify trends and patterns; identify opportunities for improvement; and develop and implement strategies to reduce the occurrence of incidents and improve the quality of CHOICES HCBS.~~

~~2.15.7.1.3 Critical incidents shall include but not be limited to the following incidents when they occur in a home and community-based long-term care service delivery setting (as defined in Section 2.15.7.1.1 above):~~

~~2.15.7.1.3.1 Unexpected death of a CHOICES member;~~

~~2.15.7.1.3.2 Suspected physical or mental abuse of a CHOICES member;~~

~~2.15.7.1.3.3 Theft or financial exploitation of a CHOICES member;~~

~~2.15.7.1.3.4 Severe injury sustained by a CHOICES member;~~

~~2.15.7.1.3.5 Medication error involving a CHOICES member;~~

~~2.15.7.1.3.6 Sexual abuse and/or suspected sexual abuse of a CHOICES member; and~~

~~2.15.7.1.3.7 Abuse and neglect and/or suspected abuse and neglect of a CHOICES member.~~

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- 2.15.7.1.4 The CONTRACTOR shall require its staff and contract CHOICES HCBS providers to report, respond to, and document critical incidents as specified by the CONTRACTOR. This shall include, but not be limited to the following:
- 2.15.7.1.4.1 Requiring that the CONTRACTOR's staff and contract CHOICES HCBS providers report critical incidents to the CONTRACTOR in accordance with applicable requirements. The CONTRACTOR shall develop and implement a critical incident reporting process, including the form to be used to report critical incidents and reporting timeframes. The maximum timeframe for reporting an incident to the CONTRACTOR shall be twenty-four (24) hours. The initial report of an incident within twenty-four (24) hours may be submitted verbally, in which case the person/agency/entity making the initial report shall submit a follow-up written report within forty-eight (48) hours.
 - 2.15.7.1.4.2 Requiring that suspected abuse, neglect, and exploitation of members who are adults is immediately reported in accordance with TCA 71-6-103 and suspected brutality, abuse, or neglect of members who are children is immediately reported in accordance with TCA 37-1-403 or TCA 37-1-605 as applicable.
 - 2.15.7.1.4.3 Requiring that its staff and contract CHOICES HCBS providers immediately (which shall not exceed twenty-four hours) take steps to prevent further harm to any and all members and respond to any emergency needs of members.
 - 2.15.7.1.4.4 Requiring that contract CHOICES HCBS providers with a critical incident conduct an internal critical incident investigation and submit a report on the investigation within the timeframe specified by the CONTRACTOR. The timeframe for submitting the report shall be as soon as possible, may be based on the severity of the incident, and, except under extenuating circumstances, shall be no more than thirty (30) days after the date of the incident. The CONTRACTOR shall review the provider's report and follow-up with the provider as necessary to ensure that an appropriate investigation was conducted and corrective actions were implemented within applicable timeframes.
 - 2.15.7.1.4.5 Requiring that its staff and contract CHOICES HCBS providers cooperate with any investigation conducted by the CONTRACTOR or outside agencies (e.g., TENNCARE, APS, CPS, and law enforcement).
 - 2.15.7.1.4.6 Defining the role and responsibilities of the fiscal employer agent (see definition in Section 1) in reporting, responding to, documenting, and investigating any critical incidents, which shall include reporting incidents to the CONTRACTOR using the process developed in accordance with Section 2.15.7.1.4.1, investigating critical incidents, submitting a report on investigations to the CONTRACTOR and reporting to the CONTRACTOR within 24 hours in accordance with the abuse and neglect plan protocols anytime there is a suspicion of abuse or neglect (see Section 2.9.7.8.6); training employees, contractors of the FEA (including supports brokers), and consumer-directed workers regarding reporting, responding to, documenting, and cooperating with the investigation of any critical incidents; and training consumers and caregivers regarding critical incident reporting and management. Such role and responsibilities shall be defined in a manner that is consistent with requirements in this Section 2.15.7.1.4 as well as TENNCARE's contract with the fiscal employer agent and the model contract between the CONTRACTOR and the FEA.

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- 2.15.7.1.4.7 Reviewing the FEA's reports and investigations regarding critical incidents and follow-up with the FEA as necessary regarding corrective actions determined by the member and/or his/her representative to help ensure the member's health and safety.
- 2.15.7.1.4.8 Providing appropriate training and taking corrective action as needed to ensure its staff, contract CHOICES HCBS providers, the FEA, and workers comply with critical incident requirements.
- 2.15.7.1.4.9 Conducting oversight, including but not limited to oversight of its staff, contract CHOICES HCBS providers, and the FEA, to ensure that the CONTRACTOR's policies and procedures are being followed and that necessary follow-up is being conducted in a timely manner.
- 2.15.7.2 Behavioral Health Adverse Occurrences
 - 2.15.7.2.1 Adverse occurrences shall include but not be limited to the following incidents when they occur while the member is in the care of a behavioral health inpatient, residential or crisis stabilization unit:
 - 2.15.7.2.1.1 Suicide death
 - 2.15.7.2.1.2 Non-suicide death
 - 2.15.7.2.1.3 Death-cause unknown
 - 2.15.7.2.1.4 Homicide
 - 2.15.7.2.1.5 Homicide Attempt with significant medical intervention
 - 2.15.7.2.1.6 Suicide Attempt with significant medical intervention
 - 2.15.7.2.1.7 Allegation of Abuse/Neglect (Physical, Sexual, Verbal)
 - 2.15.7.2.1.8 Accidental Injury with significant medical intervention
 - 2.15.7.2.1.9 Use of Restraints/Seclusion (Isolation) requiring significant medical intervention; or
 - 2.15.7.2.1.10 Treatment complications (medication errors and adverse medication reaction) requiring significant medical intervention.
 - 2.15.7.3 The CONTRACTOR shall report to TENNCARE any death and any incident that could significantly impact the health or safety of a member (e.g., physical or sexual abuse) within twenty-four (24) hours of detection or notification.
 - 2.15.7.4 As specified in Sections 2.30.12.7 and 2.30.12.8, the CONTRACTOR shall submit quarterly reports to TENNCARE regarding all critical incidents and adverse occurrences.

39. Section 2.15 shall be amended by adding a new Section 2.15.8 as follows:

2.15.8 Provider Preventable Conditions

The CONTRACTOR shall comply with 42 CFR Part 438 requirements mandating provider identification of provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in 42 CFR §434.6(a)(12) and § 447.26. The CONTRACTOR shall submit all identified Provider Preventable Conditions in a form or frequency as described by TENNCARE.

40. Section 2.16.2 shall be deleted and replaced as follows:

2.16.2 The prohibition on enrollee marketing shall not apply to health education and outreach activities (see Section 2.7.4) that are described in the CONTRACTOR's TennCare approved Annual Community Outreach Plan.

41. Section 2.17.1.1 shall be deleted and replaced as follows:

2.17.1.1 The CONTRACTOR shall submit to TENNCARE for review and prior written approval all materials that will be distributed to members (referred to as member materials). This includes but is not limited to member handbooks, provider directories, member newsletters, identification cards, fact sheets, notices, brochures, form letters, mass mailings, system generated letters and any other additional, but not required, materials and information provided to members designed to promote health and/or educate members.

42. Section 2.17.2.7 shall be amended by adding additional text as follows:

2.17.2.7 All written member materials shall be made available in alternative formats for persons with special needs at no expense to the member. Alternative formats may include, but may not be limited to: Braille, large print, and audio and shall be based on the needs of the individual enrollee. The CONTRACTOR shall have processes in place to ensure that alternative format material will be made available to the enrollee within forty five (45) days of a request;

43. Section 2.17.4.7.7 shall be deleted in its entirety and the remaining Section shall be renumbered accordingly, including any references thereto.

44. Section 2.18.5.3 shall be amended by deleting and replacing Section 2.18.5.3.14 and adding a new Section 2.18.5.3.15 as follows. The remaining Section shall be renumbered accordingly, including any references thereto.

2.18.5.3.14 Information for CHOICES HCBS providers regarding prohibition of facilitating CHOICES referrals with the expectation of being selected as the service provider or petitioning existing CHOICES members to change CHOICES providers (See Section 2.12.12.9);

2.18.5.3.15 Requirements regarding the prohibition of the reproduction and/or use of CHOICES and MFP materials and logos (See Sections 2.12.12.12 and 2.12.12.13).

45. Section 2.18.6.3.16 shall be amended by adding “and behavioral health” as follows:

2.18.6.3.16 Critical incident reporting and management for CHOICES HCBS and behavioral health providers;

46. Section 2.18.6 shall be amended by adding a new Section 2.18.6.9 and renumbering the remaining Section accordingly including any references thereto.

2.18.6.9 The CONTRACTOR shall provide documented and routine education and training to providers regarding proper billing.

47. Section 2.20.1 shall be deleted and replaced as follows and all references shall be updated accordingly.

2.20.1 General

2.20.1.1 The Tennessee Bureau of Investigation, Medicaid Fraud Control Unit (TBI MFCU) is the state agency responsible for the investigation of provider fraud and abuse in the TennCare program.

2.20.1.2 The Office of Inspector General (OIG) has the primary responsibility to investigate TennCare enrollee fraud and abuse.

2.20.1.3 The CONTRACTOR shall have surveillance and utilization control programs and procedures (42 CFR 456.3, 456.4, 456.23) to safeguard the Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments. The CONTRACTOR shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities.

2.20.1.4 The CONTRACTOR, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 CFR Part 455) on disclosure reporting. All tax-reporting provider entities that bill and/or receive TennCare funds as the result of this Agreement shall submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B and TennCare policies and procedures, including at the time of initial contracting, contract renewal, at any time there is a change to any of the information on the disclosure form, at least once every three (3) years, and at anytime upon request.

2.20.1.5 The CONTRACTOR, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 C.F.R. § 1002) on exclusion and debarment screening. All tax-reporting provider entities that bill and/or receive TennCare funds as the result of this Agreement shall screen their owners and employees against the federal exclusion databases (such as LEIE and EPLS). Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by the State.

2.20.1.6 The CONTRACTOR shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the CONTRACTOR in preventing and detecting potential fraud and abuse activities.

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- 2.20.1.7 The CONTRACTOR is prohibited from the repayment of funds paid by the CONTRACTOR to any provider when the issues, services or claims upon which the repayment is based meets one or more of the following:
- 2.20.1.7.1 Have been obtained by the State of Tennessee, either by TENNCARE directly or as part of a resolution of a state or federal investigation and/or lawsuit, including but not limited to false claims act cases; or
- 2.20.1.7.2 Have been obtained by the States Recovery Audit Contractor (RAC) contractor; or
- 2.20.1.7.3 When the issue, services or claims that are the basis of the repayment are currently being investigated by the State of Tennessee, are the subject of pending Federal or State litigation, or are being audited by the TennCare RAC.
- 2.20.1.8 This prohibition described above in Section 2.20.1.7 shall be limited to a specific provider(s), for specific dates, and for specific issues, services or claims. The CONTRACTOR shall check with the Bureau of TennCare, Program Integrity Unit before initiating any repayment of any program integrity related funds (See Section 2.20.1.7) to ensure that the repayment is permissible. In the event that the CONTRACTOR obtains funds in cases where repayment is prohibited under this section, the CONTRACTOR will return the funds to the provider.
- 2.20.1.9 The CONTRACTOR shall comply with all federal and state requirements regarding fraud and abuse, including but not limited to Sections 1128, 1156, and 1902(a)(68) of the Social Security Act.
- 48. Section 2.20.2 shall be amended by adding the word “subcontractors” after the word “CONTRACTOR” in Section 2.20.2.9 and by adding a new Section 2.20.2.13 as follows:**
- 2.20.2.13 In accordance with the Affordable Care Act and TennCare policy and procedures, the CONTRACTOR shall report overpayments made by TENNCARE to the CONTRACTOR as well as overpayments made by the CONTRACTOR to a provider and/or subcontractor (See Section 2.12.9.36).
- 49. Sections 2.20.3.2.7 and 2.20.3.2.8 shall be amended by adding the word “Include” to the beginning of the sentence and change the following word “A” to “a”.**
- 50. Section 2.20.3.2 shall be amended by adding new Sections 2.20.3.2.2 and 2.20.3.2.14 as follows and renumbering the remaining Section accordingly, including any references thereto.**
- 2.20.3.2.2 Include a risk assessment of the CONTRACTOR’s various fraud and abuse/program integrity processes. A risk assessment shall also be submitted on an ‘as needed’ basis and immediately after a program integrity related action, including financial-related actions (such as overpayment, repayment and fines), is issued on a provider with concerns of fraud and abuse. The CONTRACTOR shall inform TENNCARE of such action and provide details of such financial action. The assessment shall also include a listing of the CONTRACTOR’s top three vulnerable areas and shall outline action plans in mitigating such risks;
- 2.20.3.2.14 Include work plans for conducting both announced and unannounced site visits and field

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audits to providers defined as high risk (providers with cycle/auto billing activities, providers offering DME, home health, mental health, and transportation services) to ensure services are rendered and billed correctly.

51. **The renumbered Section 2.20.3.2.12 shall be amended by deleting the word “and” at the end of the sentence and the renumbered Section 2.20.3.2.13 shall be amended by deleting “.” and adding “; and” to the end of the sentence.**

52. **Section 2.20.3.6 shall be amended as follows:**

2.20.3.6 The CONTRACTOR shall have provisions in its Compliance Plan regarding conducting monthly comparison of their provider files, including atypical providers, against both the Excluded Parties List System (EPLS) and the HHS-OIG List of Excluded Individuals/Entities (LEIE) and provide a report of the result of comparison to TENNCARE each month. The CONTRACTOR shall establish an electronic database to capture identifiable information on the owners, agents and managing employees listed on providers' Disclosure forms.

53. **Section 2.22.2.1 shall be deleted and replaced as follows:**

2.22.2.1 The CONTRACTOR shall maintain a claims management system that can uniquely identify the provider of the service (ensuring all billing information related to tax-reporting business entities and information related to individuals who provide services are properly reported on claims), date of receipt (the date the CONTRACTOR receives the claim as indicated by a date-stamp), real-time-accurate history of actions taken on each provider claim (i.e., paid, denied, suspended, appealed, etc.), date of payment (the date of the check or other form of payment) and all data elements as required by TENNCARE for encounter data submission (see Section 2.23), and can track and report service use against benefit limits in accordance with a methodology set by TENNCARE.

54. **Section 2.22.2 shall be amended by adding a new Section 2.22.2.6 as follows and renumbering the remaining Section accordingly, including any references thereto.**

2.22.2.6 For any entities to which the CONTRACTOR makes payment via electronic transfers, the CONTRACTOR shall have a signed EFT form that shall have 42 CFR 455.18 and 455.19 statements immediately preceding the “Signature” section.

55. **Section 2.22 shall be amended by adding a new Section 2.22.7 as follows and renumbering the remaining Section accordingly, including any references thereto.**

2.22.7 Monthly Focused Claims Testing

2.22.7.1 In addition to the claims payment accuracy testing procedures described in Section 2.22.6, the CONTRACTOR shall perform a monthly self test on the accuracy of claims processing based on claims judgmentally selected by TDCI. The maximum number of claims selected by TDCI each month will not exceed twenty-five (25), unless TDCI, at its discretion, determines a larger sample is warranted based on the results of the accuracy tests. The results reported by the CONTRACTOR are not intended to represent the percentage of compliance or non-compliance for the total population of claims processed by the CONTRACTOR or subcontractors.

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2.22.7.2 The monthly focused claims testing procedures include:

2.22.7.2.1 The CONTRACTOR shall complete the attribute sheets provided by TDCI for each claim to be tested within thirty (30) calendar days of receipt from TDCI.

2.22.7.2.2 The CONTRACTOR shall submit a plan of correction as requested by TDCI.

56. The renumbered Section 2.22.8 shall be amended by adding a new Section 2.22.8.3 as follows and renumbering the remaining Section accordingly including any references thereto.

2.22.8.3 Identify improper payments made to invalid, missing, and/or mismatched NPIs, and/or TINs/EINs.

57. Section 2.24.4.2.4 shall be amended by deleting the reference to “Section 2.15.7.4” and replacing it with “Section 2.15.7.1.4”.

58. Section 2.26.11 shall be deleted and replaced as follows:

2.26.11 Assignability

2.26.11.1 Transportation and claims processing subcontracts shall include language requiring that the subcontract agreement shall be assignable from the CONTRACTOR to the State, or its designee: i) at the State’s discretion upon written notice to the CONTRACTOR and the affected subcontractor; or ii) upon CONTRACTOR’s request and written approval by the State. Further, the subcontract agreement shall include language by which the subcontractor agrees to be bound by any such assignment, and that the State, or its designee, shall not be responsible for past obligations of the CONTRACTOR.

2.26.11.2 Subcontractors shall not be permitted to assign TennCare funds/payments to billing agents or alternative payees without executing a billing agent or alternative payee assignment agreement. The billing agents and alternative payees are subject to initial and monthly federal exclusion (LEIE) and debarment (EPLS) screening by the assignee if the alternative payee assignment is on-going. Further, direct and indirect payments to out of country individuals and/or entities are prohibited.

59. Section 2.27 shall be deleted and replaced as follows:

2.27 COMPLIANCE WITH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AND HEALTH INFORMATION TECHNOLOGY FOR ECONOMIC AND CLINICAL HEALTH ACT (HITECH)

2.27.1 TENNCARE and the CONTRACTOR shall comply with obligations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH) under the American Recovery and Reinvestment Act of 2009 (ARRA) and their accompanying regulations, and as amended.

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2.27.2 The CONTRACTOR warrants to TENNCARE that it is familiar with the requirements of HIPAA and HITECH and their accompanying regulations, and shall comply with all applicable HIPAA and HITECH requirements in the course of this Agreement including but not limited to the following:

2.27.2.1 Compliance with the Privacy Rule, Security Rule, and Notification Rule;

2.27.2.2 The creation of and adherence to sufficient Privacy and Security Safeguards and Policies;

2.27.2.3 Timely Reporting of Violations in the Access, Use and Disclosure of PHI; and

2.27.2.4 Timely Reporting of Privacy and/or Security Incidents.

2.27.2.5 Failure to comply may result in actual damages that the State incurs as a result of the breach and liquidated damages in accordance with Section 5.20.

2.27.3 The CONTRACTOR warrants that it shall cooperate with TENNCARE, including cooperation and coordination with TENNCARE privacy officials and other compliance officers required by HIPAA and HITECH and their accompanying regulations, in the course of performance of the Agreement so that both parties will be in compliance with HIPAA and HITECH.

TENNCARE and the CONTRACTOR shall sign documents, including, but not limited to, business associate agreements, as required by HIPAA and HITECH, that are reasonably necessary to keep TENNCARE and the CONTRACTOR in compliance with HIPAA and HITECH.

2.27.4 As a party to this Agreement, the CONTRACTOR hereby acknowledges its designation as a covered entity and/or business associate under the HIPAA regulations and agrees to comply with all applicable HIPAA and HITECH (hereinafter "HIPAA/HITECH") regulations.

2.27.5 In accordance with HIPAA/HITECH regulations, the CONTRACTOR shall, at a minimum:

2.27.5.1 Comply with requirements of the Health Insurance Portability and Accountability Act of 1996 and the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH), including, but not limited to, the transactions and code sets, privacy, security, and identifier regulations, by their designated compliance dates. Compliance includes meeting all required transaction formats and code sets with the specified data sharing agreements required under the regulations;

2.27.5.2 Transmit/receive from/to its providers, subcontractors, clearinghouses and TENNCARE all transactions and code sets required by the HIPAA/HITECH regulations in the appropriate standard formats, utilizing appropriate and adequate safeguards, as specified under the law and as directed by TENNCARE so long as TENNCARE direction does not conflict with the law;

2.27.5.3 Agree that if it is not in compliance with all applicable standards defined within the transactions and code sets, privacy, security and all subsequent HIPAA/HITECH standards, that it will be in breach of this Agreement and will then take all reasonable steps to cure the breach or end the violation as applicable. Since inability to meet the transactions and code sets requirements, as well as the privacy and security requirements can bring basic business practices between TENNCARE and the CONTRACTOR and between the CONTRACTOR

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and its providers and/or subcontractors to a halt, if for any reason the CONTRACTOR cannot meet the requirements of this Section, TENNCARE may terminate this Agreement in accordance with the Business Associate Agreement ancillary to this Agreement;

- 2.27.5.4 Ensure that Protected Health Information (PHI) exchanged between the CONTRACTOR and TENNCARE is used only for the purposes of treatment, payment, or health care operations and health oversight and its related functions. All PHI not transmitted for these purposes or for purposes allowed under the federal HIPAA/HITECH regulations shall be de-identified to secure and protect the individual enrollee's PHI;
- 2.27.5.5 Report to TENNCARE's Privacy Office immediately upon becoming aware of any use or disclosure of PHI in violation of this Agreement by the CONTRACTOR, its officers, directors, employees, subcontractors or agents or by a third party to which the CONTRACTOR disclosed PHI;
- 2.27.5.6 Specify in its agreements with any agent or subcontractor that will have access to PHI that such agent or subcontractor agrees to be bound by the same restrictions, terms and conditions that apply to the CONTRACTOR pursuant to this Section;
- 2.27.5.7 Make available to TENNCARE enrollees the right to amend their PHI in accordance with the federal HIPAA regulations. The CONTRACTOR shall also send information to enrollees educating them of their rights and necessary steps in this regard;
- 2.27.5.8 Make an enrollee's PHI accessible to TENNCARE immediately upon request by TENNCARE;
- 2.27.5.9 Make its internal policies and procedures, records and other documentation related to the use and disclosure of PHI available to the U.S. Secretary of Health and Human Services for the purposes of determining compliance with the HIPAA/HITECH regulations upon request;
- 2.27.5.10 Create and adopt policies and procedures to periodically audit adherence to all HIPAA/HITECH regulations, and for which CONTRACTOR acknowledges and promises to perform, including but not limited to, the following obligations and actions:
 - 2.27.5.10.1 Agree to ensure that any agent, including a subcontractor, to whom it provides PHI that was created, received, maintained, or transmitted on behalf of TENNCARE agrees to use reasonable and appropriate safeguards to protect the PHI.
- 2.27.5.11 If feasible, return or destroy all PHI, in whatever form or medium (including any electronic medium) and all copies of an any data or compilations derived from and allowing identification of any individual who is a subject of that PHI upon termination, cancellation, expiration or other conclusion of the Agreement, and in accordance with this Section of this Agreement. The CONTRACTOR shall complete such return or destruction as promptly as possible, but not later than thirty (30) days after the effective date of the termination, cancellation, expiration or other conclusion of the Agreement. The CONTRACTOR shall identify any PHI that cannot feasibly be returned or destroyed. Within such thirty (30) days after the effective date of the termination, cancellation, expiration or other conclusion of the Agreement, the CONTRACTOR shall: (1) certify on oath in writing that such return or destruction has been completed; (2) identify any PHI which cannot feasibly be returned or destroyed; and (3) certify that it will only use or disclose such PHI for those purposes that make its return or destruction infeasible;

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- 2.27.5.12 Implement all appropriate administrative, physical and technical safeguards to prevent the use or disclosure of PHI other than pursuant to the terms and conditions of this Agreement and, including, but not limited to, privacy, security and confidentiality requirements in 45 CFR Parts 160 and 164;
 - 2.27.5.13 Set up appropriate mechanisms to limit use or disclosure of PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure;
 - 2.27.5.14 Create and implement policies and procedures to address present and future HIPAA/HITECH regulatory requirements as needed, including, but not limited to: use and disclosure of data; de-identification of data; minimum necessary access; accounting of disclosures; enrollee's right to amend, access, request restrictions; notice of privacy practices and right to file a complaint;
 - 2.27.5.15 Provide an appropriate level of training to its staff and employees regarding HIPAA/HITECH-related policies, procedures, enrollee rights and penalties prior to the HIPAA/HITECH implementation deadlines and at appropriate intervals thereafter;
 - 2.27.5.16 Track training of CONTRACTOR staff and employees and maintain signed acknowledgements by staff and employees of the CONTRACTOR's HIPAA/HITECH policies;
 - 2.27.5.17 Be allowed to use and receive information from TENNCARE where necessary for the management and administration of this Agreement and to carry out business operations where permitted under the regulations;
 - 2.27.5.18 Be permitted to use and disclose PHI for the CONTRACTOR's own legal responsibilities;
 - 2.27.5.19 Adopt the appropriate procedures and access safeguards to restrict and regulate access to and use by CONTRACTOR employees and other persons performing work for the CONTRACTOR to have only minimum necessary access to PHI and personally identifiable data within their organization;
 - 2.27.5.20 Continue to protect and secure PHI AND personally identifiable information relating to enrollees who are deceased;
 - 2.27.5.21 Be responsible for informing its enrollees of their privacy rights in the manner specified under the regulations;
 - 2.27.5.22 Make available PHI in accordance with 45 CFR 164.524;
 - 2.27.5.23 Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR 164.526; and
 - 2.27.5.24 Obtain a third (3rd) party certification of their HIPAA transaction compliance ninety (90) calendar days before the start date of operations.
- 2.27.6 The CONTRACTOR shall track all security incidents as defined by HIPAA/HITECH, and, as required by the HIPAA/HITECH Reports. The CONTRACTOR shall periodically report in summary fashion such security incidents.

2.27.7 TENNCARE and the CONTRACTOR are “information holders” as defined in TCA 47-18-2107. In the event of a breach of the security of CONTRACTOR’s information system, as defined by TCA 47-18-2107, the CONTRACTOR shall indemnify and hold TENNCARE harmless for expenses and/or damages related to the breach. Such obligations shall include, but not be limited to, mailing notifications to affected enrollees. Substitute notice to written notice, as defined by TCA 47-18-2107(e)(2)and(3), shall only be permitted with TENNCARE’s express written approval. The CONTRACTOR shall notify TENNCARE’s Privacy Office immediately upon becoming aware of any security incident that would constitute a “breach of the security of the system” as defined in TCA 47-18-2107.

2.27.8 NOTIFICATION OF BREACH & NOTIFICATION OF PROVISIONAL BREACH. The CONTRACTOR shall notify TENNCARE’s Privacy Office immediately upon becoming aware of any incident, either confirmed or provisional, that represents or *may* represent unauthorized access, use or disclosure of encrypted or unencrypted computerized data that materially compromises the security, confidentiality, or integrity of enrollee PHI maintained or held by the CONTRACTOR, including any unauthorized acquisition of enrollee PHI by an employee or otherwise authorized user of the CONTRACTOR’s system. This includes, but is not limited to, loss or *suspected* loss of remote computing or telework devices such as laptops, PDAs, Blackberrys or other Smartphones, USB drives, thumb drives, flash drives, CDs, and/or disks.

60. Section 2.28.2 and 2.28.3 shall be deleted and replaced as follows:

2.28.2 In order to demonstrate compliance with federal and state regulations of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), the Church Amendments (42 U.S.C. 300a-7), Section 245 of the Public Health Service Act (42 U.S.C. 238n.), and the Weldon Amendment (Consolidated Appropriations Act 2008, Public Law 110-161, Div. G, Sec. 508 (d), 121 Stat. 1844, 2209), the CONTRACTOR shall designate a staff person to be responsible for non-discrimination compliance as required in Section 2.29.1.

2.28.2.1 This person shall develop a CONTRACTOR non-discrimination compliance training plan within thirty (30) days of the implementation of this Agreement, to be approved by the Bureau of TennCare. This person shall be responsible for the provision of instruction regarding the plan to all CONTRACTOR staff within sixty (60) days of the implementation of this Agreement. This person shall be responsible for the provision of instruction regarding the plan to providers and direct service subcontractors within ninety (90) days of the implementation of this Agreement. The CONTRACTOR shall be able to show documented proof of such instruction.

2.28.3 The CONTRACTOR’s non-discrimination compliance plan shall include written policies and procedures that demonstrate non-discrimination in the provision of services to members. The policy shall also demonstrate non-discrimination in the provision of services for members with Limited English Proficiency and those requiring communication assistance in alternative formats (see Section 2.18.2). These policies and procedures shall be prior approved in writing by TENNCARE.

61. Section 2.30.3 shall be deleted and replaced as follows:

2.30.3 Annual Community Outreach Plan

The CONTRACTOR shall submit an *Annual Community Outreach Plan* no later than November 30 of each year for review and approval by TENNCARE. The Annual Community Outreach Plan shall be written in accordance with guidance prepared by TENNCARE. It shall include, but is not limited to: all proposed community/health education events related to TENNderCare; community/health education events unrelated to TENNderCare; rationale for participating in these events; and a process for evaluating the benefits of the events.

62. The lead in paragraph of Section 2.30.6.5 shall be deleted and replaced as follows:

2.30.6.5 Upon enrollment of CHOICES Group 2 or 3 members (if and when directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3), the CONTRACTOR shall submit a monthly *CHOICES HCBS Late and Missed Visits Report* for CHOICES members regarding the following CHOICES HCBS: personal care, attendant care, homemaker services, and home-delivered meals. The report shall include information on specified measures, which shall include but not be limited to the following:

63. Section 2.30.6 shall be amended by adding a new Section 2.30.6.8 as follows and renumbering the remaining Section accordingly, including any references thereto.

2.30.6.8 Beginning April 2012, the CONTRACTOR shall submit a monthly *CHOICES Caseload and Staffing Ratio Report*.

2.30.6.8.1 The report shall reflect the weighted care coordinator-to-CHOICES member staffing ratios and care coordinator caseloads on the last business day of the month prior to the report submission (e.g. the report submitted in April 2012 will reflect the weighted caseloads and staffing ratios as they appeared on March 31, 2012);

2.30.6.8.2 The report shall include at a minimum;

2.30.6.5.1.1 The weighted average care coordinator-to CHOICES member staffing ratio; and

2.30.6.8.2.1 The weighted caseload of CHOICES member assignments to each individual care coordinator.

64. Section 2.30 shall be amended by adding a new Section 2.30.7 as follows and renumbering the remaining section accordingly, including any references thereto.

2.30.7 Integrated Health Services Delivery Model Reports

2.30.7.1 For the first two (2) months following implementation of SelectCommunity in each Grand Region, or as long as determined necessary by TENNCARE, the CONTRACTOR shall submit a monthly *Status of Transitioning SelectCommunity Members Report*. The report shall include information on the CONTRACTOR's current and cumulative performance on various measures. The performance measures shall include but not be limited to the following:

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- 2.30.7.1.1 Of SelectCommunity members who were enrolled in Select as of the most recent phased implementation date;
 - 2.30.7.1.1.1 the number and percent for whom the CONTRACTOR has/has not assigned a nurse care manager within 5 days of enrollment (see Section 3.A.5.1);
 - 2.30.7.1.1.2 the number and percent for whom the CONTRACTOR has/ has not provided written notice to the member within 10 days of enrollment;
 - 2.30.7.1.1.3 the number and percent for whom the CONTRACTOR has/has not conducted a face-to-face visit and a comprehensive needs assessment prior to development of the integrated plan of health care; and
 - 2.30.7.1.1.4 the number and percent for whom the CONTRACTOR has/ has not developed and authorized a new integrated plan of health care within 30 days of the member's enrollment.

- 2.30.7.2 The CONTRACTOR shall submit a quarterly Reassessment of *SelectCommunity Members' Needs Report*. The report shall include information on the CONTRACTOR's current and cumulative performance on various measures. The performance measures shall include but not be limited to the following:
 - 2.30.7.2.1 the number and percent of SelectCommunity members for whom the CONTRACTOR has/ has not reassessed the member's physical and behavioral health needs at least annually (defined as within 365 days of the member's enrollment date) as defined in section 3.A.8.1; and
 - 2.30.7.2.2 the number and percent of SelectCommunity members for whom the CONTRACTOR has/ has not reassessed the member's physical and behavior health needs within 10 days of becoming aware that the member's functional, physical, or behavioral status has changed significantly as defined by not limited to section 3.A.8.1.1 thru 3.A.8.1.5.
- 2.30.7.3 The CONTRACTOR shall submit a quarterly *SelectCommunity Nurse Care Management Assignment Report*, in a format specified by TENNCARE that includes, but is not limited to the following:
 - 2.30.7.3.1 The member name, SSN, and DOB;
 - 2.30.7.3.2 Whether the member has complex unstable physical or behavioral health needs (see Section 3.A.14.3.), complex stable physical or behavioral health needs (see Section 3.A.14.4), or no complex physical or behavioral health needs;
 - 2.30.7.3.3 The assigned Nurse Care Manager (NCM) name, email address, and direct phone number;
 - 2.30.7.3.4 The NCM Supervisor name, email, and direct phone number;
 - 2.30.7.3.5 The average NCM-to-SelectCommunity member staffing ratio for 1) Arlington class members and 2) other SelectCommunity members on the last business day of the month prior to the report submission (e.g., the report submitted in January 2012 will reflect the average staffing ratios as they appeared on December 31, 2011); and

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- 2.30.7.3.6 The number of Arlington class members and other SelectCommunity members assigned to each individual Nurse Care Manager on the last business day of the month prior to the report submission (e.g., the report submitted in January 2012 will reflect Nurse Care Manager assignments as they appeared on December 31, 2011).
- 2.30.7.4 The CONTRACTOR shall submit a quarterly *SelectCommunity Nurse Care Management Contacts Report*, in a format specified by TENNCARE. The report shall include information on the CONTRACTOR's current and cumulative performance on various measures which shall include but not be limited to the following:
 - 2.30.7.4.1 The number and percent of SelectCommunity members with complex unstable physical or behavioral health needs visited/ not visited in their residence face-to-face by their Nurse Care Manager at least monthly;
 - 2.30.7.4.2 The number and percent of SelectCommunity members with complex stable physical or behavioral health needs contacted/ not contacted by their Nurse Care Manager at least monthly either in person or by telephone, and visited/ not visited in their residence face-to-face by their Nurse Care Manager at least quarterly; and
 - 2.30.7.4.3 The number and percent of SelectCommunity members with no complex physical or behavioral health needs contacted/ not contacted by their Nurse Care Manager at least quarterly either in person or by telephone, and visited/ not visited in their residence face-to-face by their Nurse Care Manager at least semi-annually.
- 2.30.7.5 The CONTRACTOR shall submit to TennCare a monthly *SelectCommunity Delays in Service Report* as defined in Section 3.A.7.13.

65. The renumbered Section 2.30.10 shall be renumbered and re-organized as follows:

2.30.10 Provider Payment Reports

- 2.30.10.1 The CONTRACTOR shall submit a quarterly *Related Provider Payment Report* that lists all related providers and subcontractors to whom the CONTRACTOR has made payments during the previous quarter and the payment amounts. (See Section 2.13.20.).
- 2.30.10.2 The CONTRACTOR shall submit a weekly *Invoice* to notify the State of the amount to be paid to providers at least 72 hours in advance of distribution of provider checks.
- 2.30.10.3 The CONTRACTOR shall submit a *Check Register Report* with the weekly Invoice to support the payments released to providers.
- 2.30.10.4 The CONTRACTOR shall submit a *Claims Data Extract* within seven (7) calendar days after the CONTRACTOR's request of the funds which shall be generated from the managed care claims processing system supporting the release of provider and FEA (for consumer-directed workers, as applicable) payments. (See Section 2.13.1.)
- 2.30.10.5 The CONTRACTOR shall submit a *Reconciliation Report* within seven (7) days of the claims data extract for the total paid amounts between the funds released for payment to providers and the FEA (for consumer-directed workers, as applicable), the supporting claims data extract, and the encounter data submissions for the relevant adjudication cycle.

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2.30.10.6 If the CONTRACTOR does not automatically credit TennCare for receivables within ninety (90) calendar days, the CONTRACTOR shall submit a *Provider Payment Issue Report* and shall determine the extent of the collection effort required based on the table below. This table identifies the minimum collection threshold for cumulative receivable balances. All collection efforts shall be clearly documented.

Receivable Balance	Collection	Attempts	Forwarded to Collections
	45 Day	90 Day	
< \$10	None Required		
\$10 - \$49.99	✓		
\$50 - \$99.99	✓	✓	
\$100 - Over	✓	✓	✓
Responsibility	MCC		TENNCARE

2.30.10.6.1 The first notice shall occur by day forty-five (45) and may be in the form of notice in a remittance advice or a demand memo; however, the ninety (90) day notice must be made using a demand memo. Each of these notices shall be sent within five (5) business days of becoming due.

2.30.10.6.2 Additional collection attempts by the CONTRACTOR are not necessary if a collection notice is returned because the provider has gone out-of-business or has declared bankruptcy for the period the receivable was established. This circumstance must be reported in the "Uncollectible Accounts Report" as described below.

2.30.10.7 If the CONTRACTOR does not automatically credit TENNCARE for aged accounts within sixty (60) calendar days, the CONTRACTOR shall submit to TENNCARE, within ten (10) business days following the end of the month, an *Aged Accounts Receivable Report*. The effective date of this report shall be the last Friday of the previous month. The report shall have an easily identifiable date, contain a total report balance, and provide <30, 30, 60, 90, and >120 calendar day balances. Although only totals are required, the CONTRACTOR may report aging balances at the account level. If the CONTRACTOR is not reporting at the account level, the CONTRACTOR shall have the capability to identify the detail that makes up a total if necessary.

2.30.10.8 If the CONTRACTOR does not automatically credit TENNCARE for uncollectible accounts within ninety (90) calendar days, the CONTRACTOR shall submit to TENNCARE, within ten (10) business days following the end of the month, an *Uncollectible Accounts Report*.

2.30.10.8.1 The report shall be in a format described by TENNCARE, for accounts meeting the following criteria:

2.30.10.8.1.1 The account proves to be uncollectible after 120 calendar days, or

2.30.10.8.1.2 The provider account owner has gone out-of-business, or

2.30.10.8.1.3 The provider account owner has declared bankruptcy.

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- 2.30.10.8.2 In addition to the Uncollectible Accounts Report, the CONTRACTOR shall submit scanned copies of returned envelopes or legal documents referencing providers that have gone out-of-business and/or declared bankruptcy.
- 2.30.10.9 The CONTRACTOR shall submit a monthly *Outstanding Checks Report* detailing all checks remitted to providers, enrollees or vendors on behalf of the State which remain outstanding (which have not been cashed) greater than one hundred eighty (180) calendar days. Reports are due within fifteen (15) business days after the end of the month.
- 2.30.10.10 Upon notification by TENNCARE, the CONTRACTOR shall submit a weekly *Administrative Services Only Invoice Report* for all payments to clinics designated as Federally Qualified Health Clinics or Rural Health Clinics

66. The renumbered Section 2.30.11.2 shall be deleted and replaced as follows:

~~2.30.11.2 The CONTRACTOR shall submit quarterly *Cost and Utilization Reports*. These reports shall be in an Excel spreadsheet format and submitted with a ninety (90) day lag and shall be due to TENNCARE one hundred twenty (120) calendar days following the quarter for which the CONTRACTOR is reporting. These reports shall be submitted on both a cumulative year basis and on a rolling twelve (12) month basis.~~

67. The renumbered Section 2.30.11.7 shall be deleted and replaced as follows:

~~2.30.11.7 The CONTRACTOR shall submit a semi-annual *Emergency Department Threshold Report* (See Section 2.14.1.16.1) to TENNCARE no later than March 31st and September 30th each year identifying interventions initiated for members who exceeded the defined threshold for ED usage.~~

68. The renumbered Section 2.30.12 shall be amended by adding a new Section 2.30.12.5 as follows and renumbering the remaining Sections accordingly, including any references thereto.

2.30.12.5 The CONTRACTOR shall submit to TENNCARE by June 15 of each calendar year a detailed explanation for any Medicaid HEDIS measure marked as "Not Reported".

69. The renumbered Section 2.30.12 shall be amended by adding a new Section 2.30.12.8 as follows and renumbering the remaining Sections accordingly, including any references thereto.

2.30.12.8 The CONTRACTOR shall submit a quarterly Behavioral Health Adverse Occurrences Report in accordance with Section 2.15.7.2 that provides information, by month regarding specified measures, which shall include but not be limited to the following:

2.30.12.8.1 The number of adverse occurrences, overall and by:

2.30.12.8.1.1 Date of occurrence

2.30.12.8.1.2 Type of adverse occurrence;

- 2.30.12.8.1.3 Location;
- 2.30.12.8.1.4 Provider name; and
- 2.30.12.8.1.5 Action Taken by Facility/Provider.

70. The renumbered Section 2.30.15.4 shall be deleted in its entirety and replaced as follows:

2.30.15.4 Effective July 1, 2012, the CONTRACTOR shall submit a quarterly *Disclosure Submission Rate report* which shall provide the percentage of providers for which the CONTRACTOR has obtained a complete and current disclosure form in accordance with 42 CFR 455, TennCare policies and procedures, and this Agreement (see Section 2.12.9.37). The rate shall be provided for all tax-reporting entities with billing activities during the prior quarter. The quarterly report shall include a companion listing which shall include all tax-reporting entities with reimbursement amounts received in the prior reporting quarter along with the disclosure status. For all subcontractors and providers with a signed contract and/or with billing activities, the CONTRACTOR shall maintain a minimum of ninety-five percent (95%) compliance on all entities excluding providers who bill under emergency provisions. Should the CONTRACTOR attain a disclosure rate below ninety-five percent (95%), the CONTRACTOR shall be subject to liquidated damages and shall submit a corrective action plan that shall address the root causes of the non-compliance.

71. The renumbered Section 2.30.15.5 shall be amended as follows:

2.30.15.5 The CONTRACTOR shall submit a monthly *Program Integrity Exception List report* that identifies employees or contractors (as defined in Section 2.21.9) that have been reported on the HHS-OIG LEIE (List of Excluded Individuals/Entities) (http://oig.hhs.gov/fraud/exclusions/exclusions_list.asp), the Excluded Parties List System (EPLS), and/or the listing of Monthly Disciplinary Actions issued by the Professional Health Board.

72. The renumbered Section 2.30.17 shall be amended by adding a new Section 2.30.17.2 and the renumbered Section 2.30.17.4 shall be amended by adding the phrase “number of adjustments (including repayments),” as follows. The remaining Section shall be renumbered accordingly including any references thereto:

2.30.17.2 The CONTRACTOR shall submit a monthly *Focused Claims Testing Report*. The report shall include the results of the self test on the accuracy of claims processing based on claims that have been judgmentally selected by TDCI (see Section 2.22.7). The CONTRACTOR shall complete the attribute sheets provided by TDCI for each claim to be tested within thirty (30) calendar days of receipt from TDCI.

2.30.17.4 The CONTRACTOR shall submit a weekly *Claims Activity Report*. This report shall identify the number of claims received, number of claims denied (by reason), number of claims paid, number of adjustments (including repayments), and total amount paid by the categories of service specified by TENNCARE.

73. The renumbered Section 2.30.21 shall be deleted and replaced as follows:

2.30.21 HIPAA/HITECH Reports

The CONTRACTOR shall submit a *Privacy/Security Incident Report*. This report shall be provided at least annually, but the CONTRACTOR shall provide the report more frequently if requested by TENNCARE. The report shall include, at a minimum, the date of the incident, the date of notification to TENNCARE's privacy officer, the nature and scope of the incident, the CONTRACTOR's response to the incident, and the mitigating measures taken by the CONTRACTOR to prevent similar incidents in the future. Upon TENNCARE's request, the CONTRACTOR shall provide additional details within a reasonable amount of time. "Port scans" or other unsuccessful queries to the CONTRACTOR's information system shall not be considered a privacy/security incident for purposes of this report.

74. Section 3.A.2 shall be deleted and replaced as follows:

3A.2 Target Population for the Integrated Health Services Delivery Model

3A.2.1 Upon implementation of the Integrated Health Services Delivery Model for persons with intellectual disabilities and in accordance with the phased-in implementation plan set forth in this Section, the CONTRACTOR shall provide Nurse Care Management to all TennCare Select members with intellectual disabilities who are actively enrolled in one of the State of Tennessee's three (3) Section 1915(c) Home and Community Based Services (HCBS) waiver programs for persons with intellectual disabilities (i.e., mental retardation), including the Arlington, Statewide (or "Main") and Self-Determination Waiver Programs.

3A.2.2 The CONTRACTOR shall also provide Nurse Care Management to all TennCare Select members in the Arlington Class who are residing in public or private ICFs/MR, nursing homes or in other institutional or alternative home and community-based placements, which may include the person's (or family's) home, except that persons enrolled in the CHOICES program shall not participate in the Integrated Health Services Delivery Model. TennCare shall determine, at its discretion, whether Arlington class members in nursing homes will be enrolled into CHOICES or into the Integrated Health Services Delivery Model. If the State elects to enroll Arlington class members in nursing homes into the Integrated Health Services Delivery Model Arlington class members who elect to opt out of the Integrated Health Services Delivery Model shall be required to enroll in CHOICES in order to receive nursing home services.

3A.2.3 The CONTRACTOR shall provide Nurse Care Management *only* to members of the target population as defined in this Section. Nurse Care Management shall not be available to persons outside the defined target population for the Integrated Health Services Delivery Model.

3A.2.4 TENNCARE will notify the CONTRACTOR regarding Arlington Class Members currently served by the Community Services Network (CSN) who elect to opt into TennCare Select and participate in the Integrated Health Services Delivery Model.

3A.2.5 For other members of the target population, TENNCARE will notify the CONTRACTOR via the 834 eligibility file when the member has been enrolled in TennCare Select, either because:

- (a) s/he is in the defined target population and has elected to opt into TennCare Select; or
- (b) because s/he has been auto-assigned (with an opt out provision) by virtue of being a new TennCare member who meets ICF/MR level of care eligibility and is:
 - (1) actively enrolled in an MR Waiver program; or

Amendment Number 27 (cont.)

- (2) upon approval by CMS of an amendment to the State's Section 1115 TennCare Demonstration Waiver, is:
 - (a) receiving ICF/MR services; or
 - (b) a member of the Arlington At-Risk Class.

Additional notification processes may be established as necessary to help facilitate timely initiation of the CONTRACTOR's care management (including assessment) activities; however, only members assigned to TennCare Select by TennCare (i.e., based on auto-assignment, exercise of an opt-in opportunity, or an MCO change request) may participate in the Integrated Health Services Delivery Model.

75. Section 3.A.3.3 and 3A.3.4 shall be deleted and replaced as follows:

3A.3.3 Approximately 120 days later, TennCare shall begin expanding the model to other members of the target population, on a Grand Region by Grand Region basis, until all persons in the target population have been given an opportunity to opt into TennCare Select and participate in the Integrated Health Services Delivery Model. ~~At TennCare's discretion, notice and transition processes for other members of the target population may be scheduled to facilitate a more seamless transition process.~~

3A.3.4 All members of the target population assigned to TennCare Select that elect to participate shall be assigned to the Integrated Health Services Delivery Model.

76. Section 3.A.14.7 shall be deleted and replaced as follows:

3A.14.7 The CONTRACTOR shall provide, at least sixty (60) days prior to implementation of the Integrated Health Services Delivery Model for Arlington class members, and at least sixty (60) days prior to an implementation phase in a particular Grand Region, a Nurse Care Management Staffing Plan, which shall specify the number of Nurse Care Managers, Nurse Care Manager Supervisors, other supporting Care Management Support Team members the CONTRACTOR plans to initially employ. TENNCARE shall notify the CONTRACTOR in writing if the Nurse Care Management Staffing Plan is insufficient and may require modifications to ensure, prior to implementation of the Integrated Health Services Delivery Model, that the CONTRACTOR has sufficient Nurse Care Management staff. After the Integrated Health Services Delivery Model has been implemented, the CONTRACTOR shall notify TENNCARE in writing of substantive changes to its Nurse Care Management Staffing Plan, including a variance of twenty (20) percent or more from the Staffing Plan. TENNCARE may request changes in the CONTRACTOR's Nurse Care Management Staffing Plan at any time it determines that the CONTRACTOR does not have sufficient Nurse Care Management staff to properly and timely perform its obligations under this Agreement.

77. Section 3.A.16.2 shall be deleted and replaced as follows:

3A.16.2 The CONTRACTOR shall, using a tool and methodology approved by TennCare, conduct annual consumer satisfaction surveys of TennCare Select Members in the Arlington Class who are participating in the IHSD model, and shall provide such results to TennCare for review and dissemination.

78. Section 4.8.1 shall be deleted and replaced as follows:

4.8.1 In no event shall the maximum liability of the State under this Agreement during the original term of the Agreement exceed two billion, seven hundred eighteen million, eight hundred three thousand, seven hundred five dollars and ninety cents (\$2,718,803,705.90).

Amendment Number 27 (cont.)

79. Section 5.1 shall be amended as follows:

5.1 NOTICE

All notices required to be given under this Agreement shall be given in writing, and shall be sent by United States certified mail, postage prepaid, return receipt requested; in person; by facsimile, email or other electronic means, including but not limited to providing notice through computer databases, software or other systems made available to the CONTRACTOR by TENNCARE; or by other means, so long as proof of delivery and receipt is given, and the cost of delivery is borne by the notifying party, to the appropriate party at the address given below, or at such other address (or addresses) as may be provided by notice given under this Section.

If to TENNCARE:

Deputy Commissioner
Bureau of TennCare
310 Great Circle Rd
Nashville, Tennessee 37243

If to the CONTRACTOR:

Scott Pierce
President and Chief Executive Officer
Volunteer State Health Plan, Inc.
1 Cameron Hill Circle
Chattanooga, TN 37402

80. Section 5.2.1 shall be amended by deleting “June 30, 2012” and replacing it with “June 30, 2013”.

81. Section 5.3 shall be amended by adding a new Section 5.3.2 as follows and renumbering the remaining Section 5.3 accordingly, including any references thereto.

5.3.2 42 CFR Part 438, Managed care, including but not limited to 438.6(f)(2)(i), compliance with the requirements mandating provider identification of provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in §434.6(a)(12) and § 447.26 of this subchapter.

82. Section 5.4.7.2 shall be amended by adding a new Section 5.4.7.2.7 as follows and renumbering the remaining Section accordingly, including any references thereto.

5.4.7.2.7 Promptly make available all signed provider agreements/contracts, including historical agreements/contracts, to TENNCARE in PDF format. (The CONTRACTOR shall have the option to submit said agreements on an on-going basis during the term of this Agreement rather than at the end of this Agreement). Upon termination of this Agreement and completion of the CONTRACTOR’s continuing obligations, the State will reserve all rights to pursue improper payments and false claims with the CONTRACTOR and/or directly with the CONTRACTOR’s subcontractors and providers.

83. Section 5.20.2.2.6 shall be amended by adding a new Section 5.20.2.2.6.1 as follows:

~~5.20.2.2.6 TENNCARE reserves the right to assess a general liquidated damage of five hundred dollars (\$500) per occurrence with any notice of deficiency.~~

5.20.2.2.6.1 In circumstances for which TENNCARE has applied this general liquidated damage to a notice of a deficiency that is related in any way to CHOICES care coordination processes and requirements which shall be determined by TENNCARE, the amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing recommendations as specified in Section 2.9.6.11.9 of this Agreement.

84. Sections 5.20.2.2.7, Items A.16, A.18, A.19, A.20, A.21, A.22, A.23, the renumbered Items A.28, A.29, A.30, A.31, and Item C.7 shall be amended by adding a new paragraph to the end of the existing text in the Damage column as follows:

“These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing recommendations as specified in Section 2.9.6.11.9 of this Agreement.”

85. Section 5.20.2.2.7 shall be amended by deleting and replacing Items A.23 through A.26 and adding a new Item A.27 as follows and renumbering the remaining Items.

A.23	Failure to facilitate transfers between nursing facilities or to facilitate transitions between CHOICES Groups accordance with 2.9.6.9.1.1.5 and 2.9.6.9.2.1.18	\$500 per occurrence These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing recommendations as specified in Section 2.9.6.11.9 of this Agreement
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Amendment Number 27 (cont.)

<p>A.24</p>	<p>Failure by the CONTRACTOR to ensure that all TennCare data containing protected health information (PHI), as defined by HIPAA, is secured through commercially reasonable methodology in compliance with HITECH, such that it is rendered unusable, unreadable and indecipherable to unauthorized individuals through encryption or destruction, that compromises the security or privacy of TennCare enrollee PHI (See also ancillary Business Associate Agreement between the parties)</p>	<p>\$500 per enrollee per occurrence, AND If the State deems credit monitoring and/or identity theft safeguards are needed to protect those TennCare enrollees whose PHI was placed at risk by CONTRACTOR's failure to comply with the terms of this Agreement, the CONTRACTOR shall be liable for all costs associated with the provision of such monitoring and/or safeguard services.</p>
<p>A.25</p>	<p>Failure by the CONTRACTOR to execute the appropriate agreements to effectuate transfer and exchange of TennCare enrollee PHI or TennCare confidential information including, but not limited to, a data use agreement, trading partner agreement, business associate agreement or qualified protective order prior to the use or disclosure of PHI to a third party (See ancillary Business Associate Agreement between the parties)</p>	<p>\$500 per enrollee per occurrence</p>
<p>A.26</p>	<p>Failure by the CONTRACTOR to seek express written approval from TENNCARE prior to the use or disclosure of TennCare enrollee data or TennCare confidential information in any form via any medium with any third party beyond the boundaries and jurisdiction of the United States (See ancillary Business Associate Agreement between the parties)</p>	<p>\$1,000 per enrollee per occurrence</p>

Amendment Number 27 (cont.)

A.27	Failure by the CONTRACTOR to timely report violations in the access, use and disclosure of PHI or timely report a security incident or timely make a notification of breach or notification of provisional breach (See also ancillary Business Associate Agreement between the parties)	\$500 per enrollee per occurrence, not to exceed \$10,000,000
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86. Section 5.20.2.2.7 shall be amended by deleting and replacing Items B.15 and B.21 as follows:

B.15	Failure to require and ensure compliance with Ownership and Disclosure requirements as required in Section 2.12.9.37 of this Agreement Failure to maintain complete and current disclosures/attestations for all providers excluding providers billing under emergency provisions	\$5,000 per provider disclosure/attestation for each disclosure/attestation that is not received or is received and signed by a provider that does not request or contain complete and satisfactory disclosure of the requirements outlined in 42 CFR 455, Subpart B. 92 to 95% Compliance - \$5000 per each full percentage point below 95% Under 92% Compliance - \$10,000 per each full percentage point below 95%
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B.21	Failure to meet any timeframe regarding care coordination for CHOICES members (see Sections 2.9.2, 2.9.3, and 2.9.6) other than the timeframes referenced in A.16 or A.17	<p>\$5,000 per month for each timeframe that the CONTRACTOR's performance is 85-89%</p> <p>\$10,000 per month for each timeframe that the CONTRACTOR's performance is 80-84%</p> <p>\$20,000 per month for each timeframe that the CONTRACTOR's performance is 75-79%</p> <p>\$50,000 per month for each timeframe that the CONTRACTOR's performance is 70-74%</p> <p>\$100,000 per month for each timeframe that the CONTRACTOR's performance is 69% or less</p> <p>These amounts shall be multiplied by two (2) when the CONTRACTOR has not complied with the Caseload and Staffing recommendations as specified in Section 2.9.6.11.9 of this Agreement</p>
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87. “Mental Health Case Management” Services in Attachment I shall be deleted and replaced as follows:

SERVICE	Mental Health Case Management
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DEFINITION

Mental health case management is a supportive service provided to enhance treatment effectiveness and outcomes with the goal of maximizing resilience and recovery options and natural supports for the individual. Mental health case management is consumer-centered, consumer focused and strength-based, with services provided in a timely, appropriate, effective, efficient and coordinated fashion. It consists of activities performed by a team or a single mental health case manager to support clinical services. Mental health case managers assist in ensuring the individual/family access to services.

The Case Management Society of America (CMSA) defines case management as a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual’s and family’s comprehensive health needs through communication and available resources to promote quality cost-effective outcomes.

Mental health case management requires that the mental health case manager and the individual and/or family have a strong productive relationship which includes viewing the individual/family as a responsible partner in identifying and obtaining the necessary services and resources. Services rendered to children and youth shall be consumer-centered and family-focused with case managers working with multiple systems (e.g. education, child welfare, juvenile justice). Mental health case management is provided in community settings, which are accessible and comfortable to the individual/family. The service should be rendered in a culturally competent manner and be outcome driven. Mental health case management shall be available 24 hours a day, 7 days a week. The service is not time limited and provides the individual/family the opportunity to improve their quality of life.

The CONTRACTOR shall ensure mental health case management is rendered in accordance with all of the service components and guidelines herein.

SERVICE DELIVERY

The CONTRACTOR shall:

- Determine caseload size based on an average number of individuals per case manager, with the expectation being that case managers will have mixed caseloads of clients and flexibility between Levels 1 and 2a and 2b (Levels 1 and 2 are defined below); and
- Ensure that caseload sizes and minimum contacts are met as follows:

Case Management Type	Maximum Caseload Size	Minimum Face-to-Face Contacts
Level 1 (Team Intensive Approaches) Delivered by an		

Amendment Number 27 (cont.)

Case Management Type	Maximum Caseload Size	Minimum Face-to-Face Contacts
Interdisciplinary Team		
Adult CTT	20 individuals:1 team 20 individuals:1 case manager	One (1) contact per week
Children & Youth (C&Y) CTT	15 individuals:1 team 15 individuals:1 case manager	One (1) contact per week
CCFT	15 individuals:1 team 15 individuals:1 case manager	One (1) contact per week
ACT	100 individuals:1 team 15 individuals:1 case manager	One (1) contact per week
PACT	100 individuals:1 team 15 individuals:1 case manager	One (1) contact per week
Level 2a* (Individual Intensive Approach) Delivered by a Single Case Manager	25 individuals:1 case manager	Three (3) contacts per month
Level 2b (Individual Approach) Delivered by a Single Case Manager	35 individuals:1 case manager	Two (2) contacts per month

The CONTRACTOR shall ensure that the following requirements are met:

- 1) All mental health case managers shall have, at a minimum, a bachelor's degree or be licensed as a Registered Nurse;
- 2) Supervisors shall maintain no greater than a 1:30 supervisory ratio with mental health case managers;
- 3) Mental health case managers who are assigned to both a parent(s) and child in the same family, should have skills and experience needed for both ages; mental health case managers who are assigned to individuals with co-occurring disorders (mental illness and substance abuse disorders) should have the skills and experience to meet the needs of these individuals;
- 4) A minimum of fifty-one percent (51%) of all mental health case management services should take place outside the case manager's office at the most appropriate setting;
- 5) The children and youth (C&Y) (under age eighteen (18)) mental health case management model shall provide a transition from C&Y services into adult services, including adult mental health case management services. The decision to serve an 18-year old youth via the C&Y case management system versus the adult system shall be a clinical one made by a provider. Transition from children's services, including mental health case management, shall be incorporated into the child's treatment plan; and
- 6) All mental health case management services shall be documented in a treatment plan. Mental health case management activities are correlated to expected outcomes and outcome achievement and shall be monitored, with progress being noted periodically in a written record.

Level 1

Level 1 mental health case management is the most intense level of service. It provides frequent and comprehensive support to individuals with a focus on recovery and resilience. The CONTRACTOR shall ensure the provision of level 1 mental health case management to the most severely disabled adults and emotionally disturbed children and youth, including individuals who are at high risk of future hospitalization or placement out of the home and require both community support and treatment interventions. Level 1 mental health case management shall be rendered through a team approach. Team approaches may include such models as ACT, CTT, CCFT and PACT, as described below: *Assertive Community Treatment (ACT)*

ACT is a way of delivering comprehensive and effective services to adults diagnosed with severe mental illness and who have needs that have not been well met by traditional approaches to delivering services. The principles of ACT include:

- 1) Services targeted to a specific group of individuals with severe mental illness;
- 2) Treatment, support and rehabilitation services provided directly by the ACT team;
- 3) Sharing of responsibility between team members and individuals served by the team;
- 4) Small staff (all team staff including case managers) to individual ratios (approx. 1 to 10);
- 5) Comprehensive and flexible range of treatment and services;
- 6) Interventions occurring in community settings rather than in hospitals or clinic settings;
- 7) No arbitrary time limit on receiving services;
- 8) Individualized treatment, support and rehabilitation services;
- 9) Twenty-four (24) hour a day availability of services; and
- 10) Engagement of individuals in treatment and monitoring.

Continuous Treatment Team (CTT)

CTT is a coordinated team of staff (to include physicians, nurses, case managers, and other therapists as needed) who provide a range of intensive, integrated mental health case management, treatment, and rehabilitation services to adults and children and youth. The intent is to provide intensive treatment to families of children and youth with acute psychiatric problems in an effort to prevent removal from the home to a more restrictive level of care. An array of services are delivered in the home or in natural settings in the community, and are provided through a strong partnership with the family and other community support systems. The program provides services including crisis intervention and stabilization, counseling, skills building, therapeutic intervention, advocacy, educational services, medication management as indicated, school based counseling and consultation with teachers, and other specialized services deemed necessary and appropriate.

Comprehensive Child and Family Treatment (CCFT)

CCFT services are high intensity, time-limited services designed for children and youth to provide stabilization and deter the "imminent" risk of State custody for the individual. There is usually family instability and high-risk behaviors exhibited by the child/adolescent. CCFT services are concentrated on child, family, and parental/guardian behaviors and interaction. CCFT services are more treatment oriented and situation specific with a focus on short-term stabilization goals. The primary goal of CCFT is to reach an appropriate point of stabilization so the individual can be transitioned to a less intense outpatient service.

Program of Assertive and Community Treatment (PACT)

PACT is a service delivery model for providing comprehensive community-based treatment to adults with severe and persistent mental illness. It involves the use of a multi-disciplinary team of mental health staff organized as an accountable, mobile mental health agency or group of providers who function as a team interchangeably to

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provide the treatment, rehabilitation and support services persons with severe and/or persistent mental illnesses need to live successfully in the community.

Level 2a and Level 2b

Level 2 mental health case management is a less intensive level of service than Level 1 and is focused on resilience and recovery. The CONTRACTOR shall ensure that level 2 mental health case management is provided to individuals whose symptoms are at least partially stabilized or reduced in order to allow treatment and rehabilitation efforts.

Where available, peer support might be used as an adjunct to the case manager in monitoring the service recipient prior to discharge from Level 2 case management. However, at no time should peer support in the form of Certified Peer Specialists, or any other form, become a substitute for case managers in the delivery of case management services.

SERVICE COMPONENTS

The CONTRACTOR shall ensure that mental health case management incorporates the following service components:

Crisis Facilitation

Crisis facilitation is provided in situations requiring immediate attention/resolution for a specific individual or other person(s) in relation to a specific individual. It is the process of accessing and coordinating services for an individual in a crisis situation to ensure the necessary services are rendered during and following the crisis episode. Most crisis facilitation activities would involve face-to-face contact with the individual.

Assessment of Daily Functioning

Assessment of daily functioning involves the on-going monitoring of how an individual is coping with life on a day to day basis for the purposes of determining necessary services to maintain community placement and improve level of functioning. Most assessments of daily functioning are achieved by face-to-face contact with the individual in his or her natural environment.

Assessment/Referral/Coordination

Assessment/referral/coordination involves assessing the needs of the individual for the purposes of referral and coordination of services that will improve functioning and/or maintain stability in the individual's natural environment.

Mental Health Liaison

Mental health liaison services are offered to persons who are not yet assigned to mental health case management. It is a short-term service for the purposes of service referral and continuing care until other mental health services are initiated.

Amendment Number 27 (cont.)

88. The paragraph regarding “Supported Housing” in Attachment I shall be deleted and replaced as follows:

Supported Housing

Supported housing services refers to services rendered at facilities that are staffed twenty-four (24) hours per day, seven (7) days a week with associated mental health staff supports for individuals who require treatment services and supports in a highly structured setting. These mental health services are for priority enrollees and are intended to prepare individuals for more independent living in the community while providing an environment that allows individuals to live in community settings. Given this goal, every effort should be made to place individuals in facilities near their families and other support systems and original areas of residence. Supported housing services are mental health services and do not include the payment of room and board.

Amendment Number 27 (cont.)

89. Attachment VI shall be deleted and replaced as follows:

ATTACHMENT VI
FORMS FOR REPORTING FRAUD AND ABUSE
POTENTIAL FRAUD ALLEGATION REFERRAL FORM
(template with sample data)

DATE: Month/Day/Year

TO: Office of Program Integrity

FROM: Your MCE Name

Contact Person: 1st & Last name; Telephone; EMail;

SUBJECT (ENTITY/NAME/SPECIALTY):
ABC Clinic, John Smith MD, Family Practice

SUBJECT ADDRESS/TELEPHONE:
100 Great Circle Rd, TN 37234 Phone: Fax:

PROVIDER INFORMATION(S):
HealthPlan IDs: 123456789 (Clinic) and 12345 (John Smith)
Medicaid ID(s): 7654321 (Clinic) and 9876543 (John Smith)
NPI(s): 1234567890 (Clinic) and 2345678900 (John Smith)
License – 1001 (John Smith)

DEA – 12345 (John Smith)
Tax ID – 621039594; SSN (2345678)

PROVIDER OPERATING REGION: East TN

PROVIDER INCOME:
\$374,729 (April 2, 2007 – February 7, 2011)

DATES OF SERVICE AUDITED:
November 1, 2009 – November 9, 2010

OVERPAYMENT IDENTIFIED:
\$ 31,861

ALLEGATION:
Provider is allegedly billing an excessive number of services per day.

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SOURCE/PREDICATION:

Data analysis internal lead from the Medicaid Plan

PROCEDURE CODE and MODIFIERS: 99214 – Office/outpatient visit for the evaluation and mgmt of an estab patient Mod 25 – A significant, separately identifiable service by the same physician on the same day of the procedure or other service.

Mod 59 – Distinct procedural service is distinct and or independent from other services performed on same day. Identifies procedures not normally reported together.

BILLING ENTITY:

Payments are made to the group via EFT.

MEDICAL RECORD TYPE:

Hard copy, hand written

SUMMARY OF PRELIMINARY INVESTIGATION ACTIONS:

Sampling:

A sample for 99214s with modifiers 25 and/or 59 for dates of service 11/1/09-11/9/10 was generated. The universe size was 430 whereas a sample 30 of dates of service was pulled. A total of \$100,000 was paid to the universe.

Medical Record Review and Findings:

On January 15, 2010 the medical record review was completed by an internal certified professional coder (CPC). There were a total of 138 services reviewed. The following is a summary of the services:

Service not allowed because documentation does not support service	4
Service line not allowed appears to be duplicate	1
Service not audited because documentation not provided	7
Procedure 96372 not allowed because reimbursement is included in EM CPT	16
Level of service not supported in documentation down code 99214 to 99213	24
Level of service not supported in documentation down code 99214 to 99212	1
Services appropriate for payment	85
Total Number of Services Audited	138

Modifier 25 was appended to the E/M services 97% of the time. It is inappropriate to append this modifier to an E/M service when it is billed in conjunction with laboratory services; 13 services were denied based on this rule.

Modifier 59 was appended on all ancillary codes (other than J codes) 100% of the time. It did not appear to be appropriately used in any instances. For example, claims for the therapeutic, prophylactic, or diagnostic injection and infusions (CPT 96365 or CPT 96372) that were appended with modifier 59

Amendment Number 27 (cont.)

were denied 16 times.

Under certain circumstances, it may be necessary to indicate that a procedure of service was distinct or independent from other non E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. However, when another already established modifier is appropriate it should be used rather than modifier 59, only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

Note: it is not necessary to append modifier 59 to multiple laboratory services as it does not meet the circumstances stated above.

PRIOR EDUCATIONS:

None recorded

PREPAYMENT REVIEW:

None

INTERAGENCY CONTACT:

None

ADDITIONAL SUBJECT INFORMATION:

John Smith has hospital privileges at ABC Community Hospital.

DISCLOSURE OF OWNERSHIP and CONTROL:

John Smith owns 100% of the entity.

DETERMINATION:

Based on the medical record review it has been determined that the provider is abusing "modifier 25 and 59" in order to have add on services reimbursed that are typically already covered in the reimbursement of the E/M code.

RECOMMENDATION:

Petition for the Health Plan to pursue administratively by issuing/implementing:

- Initiate pre payment review
- Demand letter for repayment
- Educate the provider on proper billing and medical record documentation.
- Initiate a Corrective Action Plan with the provider
- Continued monitoring of the provider's billing after notification of overpayment.

Amendment Number 27 (cont.)

TennCare Recommended MCC Referral Protocol:

- 1) the submission of documents related to the provider fraud and abuse referral should be via TennCare SFTP server
(**path: tncare.sftp.state.tn.us/tncare/MCC###/orr/OPI/in**) with password protections on documents;
- 2) concurrently, a notice of submission should be e-mailed to
ProgramIntegrity.TennCare@tn.gov with a subject line stating "MCC### Notice of Referral Submission via SFTP"
along with password notices on opening documents.

REPORT TENNCARE RECIPIENT FRAUD OR ABUSE

Date:

Please complete as much information as possible.

Name of Recipient/Person you are Reporting recipient name or name of individual suspected of fraud

Other Names Used (If known) alias

Social Security Number (If known)

Date of Birth

Children's Name (if applicable)

SSN, if known

DOB, if known

SSN, if known

DOB, if known

Spouse's Name (if applicable)

Street Address physical address

Apartment #

City, State, Zip city state zip

Other Addresses Used

Home Phone Number

area code

Work Phone Number (Please include)

area code

Employer's Name

Employer's Address

Employer's Phone #

area code

What is your complaint? (In your own words, explain the problem)describe suspected fraudulent behavior

Have you notified the Managed Care Contractor of this problem? Yes No

Who did you notify? (Please provide name and phone number, if known)name phone number dept/ business

Have you notified anyone else? No Yes name phone dept/ business

Requesting Drug Profile Yes No Have already received drug profile Yes No

If you are already working with a PID staff person, who?

***Please attach any records of proof that may be needed to complete the initial review.**

OIG/CID Investigator: your name

Phone number

STATE OF TENNESSEE
OFFICE OF TENNCARE INSPECTOR GENERAL
PO BOX 282368

NASHVILLE, TENNESSEE 37228

FRAUD TOLL FREE HOTLINE 1-800-433-3982 •FAX (615) 256-3852

E-Mail Address: www.tennessee.gov/tennicare (follow the prompts that read "Report Fraud Now")

Amendment Number 27 (cont.)

90. **Attachment VI shall be amended by deleting the performance standard for Non-IMD Inpatient Use in its entirety.**
91. **Section A.12.6 of Attachment XI shall be amended by deleting the reference to “4.20.2” and replacing it with the reference to “5.20.2”.**
92. **Item 14 of Exhibit A of Attachment XI shall be deleted and replaced as follows:**
 14. **Tennessee Department of Intellectual and Developmental Disabilities (DIDD):** The state agency responsible for providing services and supports to Tennesseans with mental retardation. DIDD is a division of the Tennessee Department of Finance and Administration.

Amendment Number 27 (cont.)

All of the provisions of the original Agreement not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective January 1, 2012.

The CONTRACTOR, by signature of this Amendment, hereby affirms that this Amendment has not been altered and therefore represents the identical document that was sent to the CONTRACTOR by TENNCARE.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

VOLUNTEER STATE HEALTH PLAN, INC.

BY: Mark A. Emkes
Mark Emkes
Commissioner

BY: Scott C. Pierce
Scott C. Pierce
President & CEO VSHP

DATE: 11/23/2011

DATE: 11-18-11

APPROVED BY:

APPROVED BY:

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

BY: N/A - Electronically Approved
Mark Emkes
Commissioner

BY: N/A - Electronically Approved
Justin P. Wilson
Comptroller

DATE: _____

DATE: _____

CONTRACT SUMMARY SHEET

RFS Number: 31866-00026	Contract Number: FA-02-14632-26
State Agency: Department of Finance and Administration	Division: Bureau of TennCare
Contractor	Contract Identification Number
VSHP (TennCare Select)	<input type="checkbox"/> V- <input type="checkbox"/> C-

Service Description

Managed Care Organization / Medically Necessary Health Care Services to the TennCare/Medicaid Population

Contract Begin Date

7/1/2001

Contract End Date

6/30/2012

Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66	4A2	134	11	<input type="checkbox"/> STARS		
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)	
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$ 18,599,868.48	
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$ 33,079,942.80	
2004	\$ 25,125,990.72	\$ 38,364,165.90			\$ 63,490,156.62	
2005	\$ 58,007,447.00	\$ 58,007,447.00			\$ 116,014,894.00	
2006	\$87,748,111.00	\$87,748,111.00			\$175,496,222.00	
2007	\$87,748,111.00	\$87,748,111.00			\$175,496,222.00	
2008	\$72,610,000.00	\$127,390,000.00			\$200,000,000.00	
2009	\$72,610,000.00	\$127,390,000.00			\$200,000,000.00	
2010	\$100,882,479.00	\$304,024,121.00			\$404,906,600.00	
2011	\$131,085,619.00	\$312,820,981.00			\$443,906,600.00	
2012	\$149,893,942.00	\$294,012,658.00			\$443,906,600.00	
Total:	\$ 808,252,760.35	\$ 1,466,644,345.55			\$2,274,897,105.90	

CFDA# 93.778 Title XIX Dept. of Health & Human Svcs.

Check the box ONLY if the answer is YES:

State Fiscal Contract

Name: Scott Pierce
Address: 310 Great Circle Road
 Nashville, TN
Phone: (615)507-6415

Is the Contractor a SUBRECIPIENT? (per OMB A-133)

Is the Contractor a Vendor? (per OMB A-133)

Is the Fiscal Year Funding STRICTLY LIMITED?

Procuring Agency Budget Officer Approval Signature

Is the Contractor on STARS?

Scott Pierce



Is the Contractor's FORM W-9 ATTACHED?

Is the Contractor's Form W-9 Filed with Accounts?

COMPLETE FOR ALL AMENDMENTS (only)

Funding Certification

	Base Contract & Prior Amendments	This Amendment ONLY
CONTRACT END DATE:	6/30/2012	
FY: 2002	\$ 18,599,868.48	
FY: 2003	\$ 33,079,942.80	
FY: 2004	\$ 63,490,156.62	
FY: 2005	\$116,014,894.00	
FY: 2006	\$175,496,222.00	
FY: 2007	\$175,496,222.00	
FY: 2008	\$200,000,000.00	
FY: 2009	\$200,000,000.00	
FY: 2010	\$404,906,600.00	
FY: 2011	\$443,906,600.00	
FY: 2012	\$443,906,600.00	
Total:	\$2,274,897,105.90	

Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.

M. D. Goetz, Jr.
 M.D. Goetz, Jr. ACS

AMENDMENT NUMBER 26
AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.

CONTRACT NUMBER: FA-02-14632-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as specified below.

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. Section 1 shall be amended by adding the following definitions:

Eligible Individual – With respect to Tennessee’s Money Follows the Person Rebalancing Demonstration (MFP) and pursuant to Section 6071(b)(2) of the Deficit Reduction Act as amended by Section 2403 of the Affordable Care Act (ACA), the State’s approved MFP Operational Protocol and TENNCARE Rules, a member who qualifies to participate in MFP. Such person, immediately before beginning participation in the MFP demonstration project, shall:

1. Reside in a Nursing Facility (NF) or an Intermediate Care Facility for persons with Mental Retardation (ICF/MR) and have resided for a period of not less than ninety (90) consecutive days in a Qualified Institution.
 - a. Inpatient days in an institution for mental diseases (IMDs) which includes Psychiatric Hospitals and Psychiatric Residential Treatment Facilities (PRTF) may be counted only to the extent that Medicaid reimbursement is available under the State Medicaid plan for services provided by such institution. Medicaid payments may only be applied to persons in IMDs who are over 65 or under 21 years of age.
 - b. Any days that an individual resides in a Medicare certified Skilled Nursing Facility (SNF) on the basis of having been admitted *solely* for purposes of receiving post-hospital short-term rehabilitative services covered by Medicare shall not be counted for purposes of meeting the ninety (90)-day minimum stay in a Qualified Institution established under ACA.
 - c. Short-term continuous care in a nursing facility, to include Level 2 nursing facility reimbursement, for episodic conditions to stabilize a condition rather than admit to hospital or to facilitate hospital discharge, and inpatient rehabilitation facility services reimbursed by the CONTRACTOR (i.e., *not* covered by

Amendment 26 (cont.)

Medicare) as a cost-effective alternative (see Section 2.6.5) and provided in a Qualified Institution shall be counted for purposes of meeting the ninety (90)-day minimum stay in a Qualified Institution established under ACA.

2. Be eligible for and receive Medicaid benefits for inpatient services furnished by the nursing facility or ICF/MR for at least one (1) day. For purposes of this Agreement, an Eligible Individual must reside in a nursing facility and be enrolled in CHOICES Group 1 for a minimum of one (1) day and must be eligible to enroll and transition seamlessly into CHOICES Group 2 (without delay or interruption).
3. Meet nursing facility or ICF/MR level of care, as applicable, and, but for the provision of ongoing CHOICES HCBS, continue to require such level of care provided in an inpatient facility.

Family Member - For purposes of a Qualified Residence under the State's MFP Rebalancing Demonstration, a family member includes a person with any of the following relationships to the member, whether related by blood, marriage, or adoption, and including such relationships (as applicable) that may have been established through longstanding (a year or more) foster care when the member was a minor:

1. Spouse, and parents and siblings thereof;
2. Sons and daughters, and spouses thereof;
3. Parents, and spouses and siblings thereof;
4. Brothers and sisters, and spouses thereof;
5. Grandparents and grandchildren, and spouses thereof; and
6. Domestic partner and parents thereof, including domestic partners of any individual in 2 through 5 of this definition. A domestic partner means an adult in a committed relationship with another adult. Committed relationship means one in which the member, and the domestic partner of the member, are each other's sole domestic partner (and are not married to or domestic partners with anyone else); and share responsibility for a significant measure of each other's common welfare and financial obligations.

Step and in-law relationships are included in this definition, even if the marriage has been dissolved, or a marriage partner is deceased.

Family member may also include the member's legal guardian or conservator or someone who was the legal guardian or conservator of the member when the member was a minor or required a legal guardian or conservator;

Money Follows the Person Rebalancing Demonstration (MFP) – A federal grant established under the Deficit Reduction Act and extended under the Affordable Care Act that will assist Tennessee in transitioning Eligible Individuals from a nursing facility or ICF/MR into a Qualified Residence in the community and in rebalancing long-term care expenditures. The grant provides enhanced match for HCBS provided during the first 365 days of community living following transition.

Qualified Institution – With respect to Tennessee's MFP Rebalancing Demonstration, and pursuant to Section 6071(b)(3) of the DRA, a hospital, nursing facility, or ICF/MR.

Amendment 26 (cont.)

1. An institution for mental diseases (IMDs) which includes Psychiatric Hospitals and Psychiatric Residential Treatment Facilities (PRTF) shall be a Qualified Institution only to the extent that Medicaid reimbursement is available under the State Medicaid plan for services provided by such institution. Medicaid payments may only be applied to persons in IMDs who are over 65 or under 21 years of age.
2. Any days that an individual resides in a Medicare certified Skilled Nursing Facility (SNF) on the basis of having been admitted *solely* for purposes of receiving post-hospital short-term rehabilitative services covered by Medicare shall not be counted for purposes of meeting the ninety (90)-day minimum stay in a Qualified Institution established under ACA.

Qualified Residence – With respect to Tennessee’s MFP Rebalancing Demonstration, and pursuant to Section 6071(b)(6) of the DRA, the residence in the community in which an Eligible Individual will reside upon transition to the community which shall be one of the following:

1. A home owned or leased by an Eligible Individual or the individual's family member;
2. An apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the Eligible Individual or the individual's family has domain and control; or
3. A residence in a community-based residential setting in which no more than four (4) unrelated individuals reside.

Additional requirements pertaining to a Qualified Residence set forth in MFP Policy Guidance issued by the Centers for Medicare and Medicaid Services (CMS) shall apply for all persons participating in MFP.

TENNCARE PreAdmission Evaluation System (TPAES) – A component of the State’s Medicaid Management Information System and part of the system of record for all PreAdmission Evaluation (i.e., level of care) submissions and level of care determinations, as well as enrollments into and transitions between LTC programs, including CHOICES and the State’s MFP Rebalancing Demonstration (MFP), and which shall also be used to gather data required to comply with tracking and reporting requirements pertaining to MFP.

Transition Team – Teams the CONTRACTOR may elect to establish in order to fulfill its obligations pursuant to Nursing Facility to Community Transitions (see Section 2.9.6.8) and the MFP Rebalancing Demonstration (see Section 2.9.8). If an MCO elects to use one or more Transition Teams, the Transition Team shall consist of at least one person who meets the qualifications of a care coordinator and specific other persons with relevant expertise and experience who are assigned to support the care coordinator(s) in the performance of transition activities for a CHOICES Group 1 member. All transition activities identified as responsibilities of the care coordinator shall be completed by an individual who meets all of the requirements to be a care coordinator.

2. Section 2.9.5.4 shall be amended by adding a new Section 2.9.5.4.1 as follows:

- 2.9.5.4.1 In addition to requirements pertaining to nursing facility to community transitions (see Section 2.9.6.8), members in CHOICES Group 1 who are under the age of 21 and who are residents of a nursing facility and have requested to transition home will be provided coordination of care by CHOICES and MCO Case Management staff:

Amendment 26 (cont.)

- 2.9.5.4.1.1 Member will be informed by CHOICES care coordinator of disenrollment from CHOICES upon discharge from Nursing Facility;
- 2.9.5.4.1.2 Member will be referred by CHOICES Care Coordinator to MCO Case Management within three (3) business days of the transition request, for service identification and implementation in the home setting;
- 2.9.5.4.1.3 MCO Case Manager will be responsible for developing service plan for the home setting;
- 2.9.5.4.1.4 CHOICES Care Coordinator will communicate weekly via phone or face-to-face visits with the MCO Case Management staff, the member and/or his parent or guardian (as applicable and appropriate), and the nursing facility staff to ensure timely progression of the transition plan until the transition plan is complete; and
- 2.9.5.4.1.5 Any EPSDT benefits needed by the child in the community as an alternative to nursing facility care, including medically necessary home health or private duty nursing, as applicable, shall be initiated immediately upon transition from a nursing facility (i.e., CHOICES Group 1) to the community and as of the effective date of transition with no gaps between the member's receipt of nursing facility services and EPSDT benefits.

3. Section 2.9.6.3.20.1 shall be deleted and replaced by new Sections 2.9.6.3.20.1 and 2.9.6.3.20.2 and the remaining Sections of 2.9.6.3.20 shall be renumbered accordingly, including any references thereto.

- 2.9.6.3.20.1 For purposes of the CHOICES program, service authorizations for CHOICES HCBS shall include the amount, frequency, and duration of each service to be provided, and the schedule at which such care is needed, as applicable; and other relevant information as prescribed by TENNCARE. The CONTRACTOR may determine the duration of time for which CHOICES HCBS will be authorized. However, the CONTRACTOR shall be responsible for monitoring its authorizations and for ensuring that there are no gaps in authorizations for CHOICES HCBS in accordance with the plan of care. Retroactive entry or adjustments in service authorizations for CHOICES HCBS should be made only when required to accommodate payment of services that had been authorized but an adjustment in the schedule of services was required based on the member's needs.
- 2.9.6.3.20.2 The CONTRACTOR may decide whether it will issue service authorizations for nursing facility services, or whether it will instead process claims for such services in accordance with the level of care and/or reimbursement (including the duration of such level of care and/or reimbursement) approved by TENNCARE (see Section 2.14.1.12), except that the CONTRACTOR may reimburse a lesser level of service when such lesser level of service is billed by the facility. If the CONTRACTOR elects to authorize nursing facility services, the CONTRACTOR may determine the duration of time for which nursing facility services will be authorized. However, the CONTRACTOR shall be responsible for monitoring its authorizations and for ensuring that there are no gaps in

authorizations for CHOICES nursing facility services in accordance with the level of care and/or reimbursement approved by TENNCARE. Retroactive entry or adjustments in service authorizations for nursing facility services should be made only upon notification of retroactive enrollment into or disenrollment from CHOICES Group 1a or 1b via the outbound 834 file from TENNCARE.

4. Section 2.9.6.5.1.1 shall be deleted and replaced as follows:

2.9.6.5.1.1 As part of the face-to-face intake visit for current members or face-to-face visit with new members in CHOICES Group 1, as applicable, a care coordinator shall conduct any needs assessment deemed necessary by the CONTRACTOR, using a tool prior approved by TENNCARE and in accordance with protocols specified by TENNCARE. This assessment may include identification of targeted strategies related to improving health, functional, or quality of life outcomes (e.g., related to disease management or pharmacy management) or to increasing and/or maintaining functional abilities, including services covered by the CONTRACTOR that are beyond the scope of the nursing facility services benefit. The care coordinator shall ensure coordination of the member's physical health, behavioral health, and long-term care needs and shall assess at least annually the member's potential for an interest in transition to the community. For children under the age of 21 in nursing facilities, this shall include explanation to the member or his parent or authorized representative, as applicable, of benefits available pursuant to EPSDT, including medically necessary benefits such as home health or private duty nursing that may be provided in the community as an alternative to nursing facility care.

5. Section 2.9.6.8 shall be amended by adding a new Section 2.9.6.8.2 and the remaining Section 2.9.6.8 shall be renumbered, including any references thereto.

2.9.6.8.2 Members in CHOICES Group 1 (who are residents of a nursing facility) and who are under the age of twenty-one (21) and have requested to transition home will be provided coordination of care by CHOICES and MCO Case Management staff (see Section 2.9.5.4.1).

6. Section 2.9.6.8 shall be amended by adding a new Section 2.9.6.8.16 and renumbering the remaining Sections accordingly including any references thereto.

2.9.6.8.16 Ongoing CHOICES HCBS and any medically necessary covered home health or private duty nursing services needed by the member shall be initiated immediately upon transition from a nursing facility (i.e., CHOICES Group 1) to the community (i.e., CHOICES Group 2) and as of the effective date of transition with no gaps between the member's receipt of nursing facility services and ongoing CHOICES HCBS.

7. Section 2.9.6.9.1.1.1 shall be deleted and replaced as follows:

2.9.6.9.1.1.1 Develop protocols and processes to work with nursing facilities to coordinate the provision of care. At minimum, a care coordinator assigned to a resident of the nursing facility shall participate in quarterly Grand Rounds (as defined in Section 1). At least two of the Grand Rounds per year shall be conducted on-site in the facility, and the Grand Rounds shall identify and address any member who 1) has experienced a potential significant change in needs or circumstances (see Section 2.9.6.9.1.1.5); 2) the nursing facility or MCO has expressed concerns; or 3) is under the age of twenty-one (21).

8. Section 2.9.6.9.4.3.6 shall be amended by adding new text as follows:

2.9.6.9.4.3.6 Members in CHOICES Group 1 (who are residents of a nursing facility) and who are twenty-one years of age and older shall receive a face-to-face visit from their care coordinator at least twice a year with an interval of at least one-hundred and twenty (120) days between visits. Members in CHOICES Group 1 (who are residents of a nursing facility) who are under the age of twenty-one (21) shall receive a face-to-face visit from their care coordinator at least quarterly with an interval of at least sixty (60) days between visits.

9. Section 2.9.6.9.4.3 shall be amended by adding a new Section 2.9.6.9.4.3.8 and renumbering the remaining Sections accordingly including any references thereto.

2.9.6.9.4.3.8 Members in CHOICES Group 2 participating in MFP shall, for at least the first ninety (90) days following transition to the community, be visited in their residence face-to-face by their care coordinator at least monthly with an interval of at least fourteen (14) days between contacts to ensure that the plan of care is being followed, that the plan of care continues to meet the member's needs, and the member has successfully transitioned back to the community. Thereafter, for the remainder of the member's MFP participation period, minimum contacts shall be as described in 2.9.6.9.4.3.7 unless more frequent contacts are required based on the member's needs and circumstances and as reflected in the member's plan of care, or based on a significant change in circumstances (see Sections 2.9.6.9.2.1.16. and 2.9.8.4.5) or a short-term nursing facility stay (see Sections 2.9.8.8.5 and 2.9.8.8.7).

10. The punctuation at the end of Sections 2.9.6.9.6.3.4 and 2.9.6.9.6.3.5 shall be amended as follows:

2.9.6.9.6.3.4 For members in CHOICES Group 2, a completed risk assessment and a risk agreement signed and dated by the member or his/her representative; and

2.9.6.9.6.3.5 For members in CHOICES Group 2, the cost neutrality cap provided by TENNCARE, and a determination by the CONTRACTOR that the projected cost of CHOICES HCBS, home health, and private duty nursing services will not exceed the member's cost neutrality cap.

11. Section 2.9.6.12.4 shall be deleted and replaced as follows:

2.9.6.12.4 The CONTRACTOR shall require and shall conduct readiness review activities as necessary to confirm that the EVV system vendor has a plan in place and will be compliant with all Version 5010 and ICD-10 coding requirements in a timely manner;

12. Section 2.9.6 shall be amended by adding a new Section 2.9.6.13 as follows:

2.9.6.13 TPAES

2.9.6.13.1 The CONTRACTOR shall use the TENNCARE PreAdmission Evaluation System (TPAES) to facilitate submission of all PreAdmission Evaluation (i.e., level of care) applications, including required documentation pertaining thereto, and to facilitate enrollments into and transitions between LTC programs, including CHOICES. The CONTRACTOR shall comply with all data entry and tracking processes and timelines established by TENNCARE in policy or protocol in order to ensure efficient and effective administration and oversight of the CHOICES program.

13. Section 2.9.7.4.3 shall be amended by adding new Sections 2.9.7.4.3.2 through 2.9.7.4.3.4 as follows:

2.9.7.4.3.2 If a member electing to participate in consumer direction refuses to receive eligible CHOICES HCBS from contract providers while services are initiated through consumer direction, the decision must be documented on a signed and dated Consumer Direction Participation Form. The CONTRACTOR shall not encourage a member to forego receipt of eligible CHOICES HCBS from contract providers while these HCBS are being initiated through consumer direction.

2.9.7.4.3.3 For any CHOICES Group 2 member electing to participate in consumer direction that refuses to receive eligible CHOICES HCBS from contract providers while services are initiated through consumer direction, the member's care coordinator shall visit the member face to face at least monthly to ensure that the member's needs are safely met, and shall continue to offer eligible CHOICES HCBS through contract providers.

2.9.7.4.3.4 If eligible CHOICES HCBS are not initiated within sixty (60) days following referral to the FEA, the CONTRACTOR shall notify the member that eligible CHOICES HCBS must be initiated by contract providers unless these HCBS are not needed on an ongoing basis in order to safely meet the member's needs in the community, in which case, the CONTRACTOR shall submit documentation to TENNCARE to begin the process of disenrollment from CHOICES Group 2.

14. Section 2.9.7.4.4 shall be amended as follows:

2.9.7.4.4 Except as specified in 2.9.7.4.3.2. and in accordance with requirements pertaining thereto, the CONTRACTOR shall be responsible for providing all needed eligible CHOICES HCBS using contract providers, including a back-up plan for such services, until all necessary requirements have been fulfilled in order to implement consumer direction of eligible CHOICES HCBS, including but not limited to: the

FEA verifies that workers for these services meet all necessary requirements (see Section 2.9.7.6.1 of this Agreement); service agreements are completed and signed; and authorizations for consumer directed services are in place. The CONTRACTOR, in conjunction with the FEA, shall facilitate a seamless transition between contract providers and workers and ensure that there are no interruptions or gaps in services.

15. Section 2.9 shall be amended by adding a new Section 2.9.8 and renumbering the remaining sections of 2.9 accordingly, including any references thereto.

2.9.8 Money Follows the Person (MFP) Rebalancing Demonstration

2.9.8.1 General

The MFP Rebalancing Demonstration provisions set forth in this Agreement, including but not limited to this Section 2.9.8 and MFP reporting requirements in Section 2.30 shall not apply to TennCare Select unless TENNCARE notifies the CONTRACTOR otherwise. Should TENNCARE assign enrollees to TennCare Select in accordance with this Contract, including Section 2.4.4.3.4, to serve as a backup if other MCOs fail or are deemed by TENNCARE to have inadequate MCO capacity, TENNCARE will notify TennCare Select of the applicability of the MFP provisions.

2.9.8.1.1 The CONTRACTOR shall, in accordance with this Agreement and federal and State laws, regulations, policies and protocols, assist Eligible Individuals living in a Qualified Institution in transitioning to a Qualified Residence in the community under the State's MFP Rebalancing Demonstration (MFP).

2.9.8.1.2 Eligible Individuals transitioning to a Qualified Residence in the community and consenting to participate in MFP shall be transitioned from CHOICES Group 1 into CHOICES Group 2 pursuant to TENNCARE policies and protocols for Nursing Facility-to-community transitions and shall also be enrolled into MFP. For persons enrolled in CHOICES who are also participating in MFP, the CONTRACTOR shall comply with all applicable provisions of this Agreement pertaining to the CHOICES program. This section sets forth additional requirements pertaining to the CONTRACTOR's responsibilities specifically as it relates to MFP.

2.9.8.1.3 For CHOICES Group 1 members not eligible to participate in MFP or who elect not to participate in MFP, the CONTRACTOR shall nonetheless facilitate transition to the community as appropriate and in accordance with 2.9.6.8.

2.9.8.1.4 The CONTRACTOR shall not delay a CHOICES Group 1 member's transition to the community in order to meet the ninety (90)-day minimum stay in a Qualified Institution established under ACA and enroll the person into MFP.

2.9.8.2 Identification of MFP Participants

2.9.8.2.1 The CONTRACTOR shall identify members who may have the ability and/or desire to transition from a nursing facility to the community in accordance with Section 2.9.6.8.

Amendment 26 (cont.)

- 2.9.8.2.2 The CONTRACTOR shall assess all nursing facility residents transitioning from the NF to CHOICES Group 2 for participation in MFP. This includes CHOICES Group 1 members referred for transition, as well as nursing facility residents referred for CHOICES who are not yet enrolled in CHOICES Group 1 but may be determined eligible for Group 1, and who have expressed a desire to move back into the community. However, the resident must actually be enrolled into Group 1 in order to qualify for MFP.
- 2.9.8.2.3 Members may only elect to participate in MFP and the CONTRACTOR may only enroll a member into MFP prior to the member's transition from the nursing facility to the community. Members will not be eligible to enroll in MFP if they have already transitioned out of the nursing facility.
- 2.9.8.3. Eligibility/Enrollment into MFP
- 2.9.8.3.1 Member participation in MFP is voluntary. Members may deny consent to participate in MFP or may withdraw consent to participate in MFP at any time without affecting their enrollment in CHOICES.
- 2.9.8.3.2 If a member withdraws from MFP, he cannot participate in MFP again without meeting the eligibility requirements for enrollment into MFP (e.g., following a ninety (90)-day stay in a Qualified Institution).
- 2.9.8.3.3 Only CHOICES Group 1 members who qualify to enroll in CHOICES Group 2 shall be eligible to transition to Group 2 and enroll into MFP.
- 2.9.8.3.4 In addition to facilitating transition from CHOICES Group 1 to CHOICES Group 2 pursuant to Section 2.9.6.8 of this Agreement and TENNCARE's policies and protocols, the CONTRACTOR shall facilitate the enrollment of Eligible Individuals who consent into MFP.
- 2.9.8.3.5 The member's care coordinator or, if the CONTRACTOR elects to use transition teams, a person who meets the qualifications of a care coordinator shall, using information provided by TENNCARE, provide each potential MFP participant with an overview of MFP and answer any questions the participant has. The CONTRACTOR shall have each potential MFP participant or his authorized representative, as applicable, sign an MFP Informed Consent Form affirming that such overview has been provided by the CONTRACTOR and documenting the member's decision regarding MFP participation.
- 2.9.8.3.6 Once a potential MFP participant has consented to participate in MFP, the CONTRACTOR shall notify TENNCARE within two (2) business days via the Tennessee PreAdmission Evaluation System (TPAES) unless otherwise directed by TENNCARE, and shall maintain supporting documentation as specified by TENNCARE that shall be made available to TENNCARE upon request.
- 2.9.8.3.7 The CONTRACTOR shall verify that each potential MFP participant is an Eligible Individual and shall provide attestation thereof to TENNCARE. The CONTRACTOR shall enter all required data elements into TPAES unless otherwise directed by TENNCARE, and shall maintain supporting documentation as specified by TENNCARE that shall be made available to TENNCARE upon request.

Amendment 26 (cont.)

- 2.9.8.3.8 The CONTRACTOR shall verify that each potential MFP participant will transition into a Qualified Residence in the community and shall provide attestation thereof to TENNCARE. The CONTRACTOR shall enter all required data elements into TPAES unless otherwise directed by TENNCARE and shall maintain supporting documentation as specified by TENNCARE that shall be made available to TENNCARE upon request.
- 2.9.8.3.9 Final determinations regarding whether a member can enroll into MFP shall be made by TENNCARE based on information provided by the CONTRACTOR.
- 2.9.8.3.10 TENNCARE may request and the CONTRACTOR shall submit in a timely manner additional documentation as needed to make such determination. Documentation submitted by the CONTRACTOR may be verified, to the extent practicable, by other information, either prior or subsequent to enrollment in MFP, including eligibility, claims and encounter data.
- 2.9.8.4 Participation in MFP
- 2.9.8.4.1 The participation period for MFP is 365 days. This includes all days during which the member resides in the community, regardless of whether CHOICES HCBS are received each day. Days are counted consecutively except for days during which the member is admitted to an inpatient facility.
- 2.9.8.4.2 The participation period for MFP does not include any days during which the member is admitted to an inpatient facility.
- 2.9.8.4.3 MFP participation will be “suspended” in the event a member is re-admitted for a short-term inpatient facility stay. Member will not have to re-qualify for MFP regardless of the number of days the member is in the inpatient facility, and shall be re-instated in MFP upon return to a Qualified Residence in the community.
- 2.9.8.4.4 It may take longer than 365 calendar days to complete the 365-day MFP participation period days since a member’s participation period may be interrupted by one or more inpatient facility stays.
- 2.9.8.4.5 For MFP participants, a significant change in circumstances (see 2.9.6.9.2.1.16.) shall include any admission to an inpatient facility, including a hospital, psychiatric hospital, PRTF, nursing facility or Medicare-certified Skilled Nursing Facility. The member’s Care Coordinator shall (pursuant to 2.9.6.2.4) visit the member face-to-face within five (5) business days of any inpatient facility admission and shall assess the member’s needs, conduct a comprehensive needs assessment and update the member’s plan of care, including the member’s Risk Agreement, as deemed necessary based on the member’s needs and circumstances. If the visit is conducted in the inpatient facility, the CONTRACTOR may elect to have someone who meets the qualifications of a Care Coordinator complete the required face-to-face visit and conduct a comprehensive needs assessment, in which case, the qualified individual conducting the face-to-face visit shall coordinate with the member’s Care Coordinator to update the member’s plan of care, including the member’s Risk Agreement, as deemed necessary based on the member’s needs and circumstances.

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- 2.9.8.4.6 The CONTRACTOR shall review the circumstances which resulted in the inpatient facility admission and shall evaluate whether the services and supports provided to the member are sufficient to safely meet his needs in the community such that continued participation in CHOICES Group 2 and in MFP is appropriate.
- 2.9.8.4.7 The CONTRACTOR shall notify TENNCARE within five (5) business days of admission any time a member is admitted to an inpatient facility. Such notification shall be made via TPAES unless otherwise directed by TENNCARE. The CONTRACTOR shall maintain supporting documentation as specified by TENNCARE that shall be made available to TENNCARE upon request.
- 2.9.8.4.7.1. For purposes of MFP, admission for observation (which is not considered inpatient care) shall not be considered admission to an inpatient facility. Nor shall participation in MFP be suspended during observation days.
- 2.9.8.4.8 The CONTRACTOR shall be involved in discharge planning on behalf of any MFP participant admitted to an inpatient facility.
- 2.9.8.4.9 The CONTRACTOR shall notify TENNCARE within two (2) business days when an MFP participant is discharged from a short-term stay in an inpatient facility. Such notification shall include whether the member is returning to the same Qualified Residence in which he lived prior to the inpatient stay, or a different residence which shall also be a Qualified Residence. Such notification shall be made via TPAES unless otherwise directed by TENNCARE. The CONTRACTOR shall maintain supporting documentation as specified by TENNCARE that shall be made available to TENNCARE upon request.
- 2.9.8.4.10 If at any time during the member's participation in MFP, the member changes residences, including instances in which the change in residences occurs upon discharge from an inpatient facility stay, the CONTRACTOR shall: 1) notify TENNCARE within two (2) business days of the change in residence; 2) verify that the new residence is a Qualified Residence; and 3) provide attestation thereof to TENNCARE. The CONTRACTOR shall enter all required data elements into TPAES unless otherwise directed by TENNCARE, and shall maintain supporting documentation as specified by TENNCARE that shall be made available to TENNCARE upon request.
- 2.9.8.4.11 The CONTRACTOR shall track the member's residency throughout the 365-day MFP participation period. In addition, the CONTRACTOR shall, for purposes of facilitating completion of Quality of Life surveys, continue to track MFP participants' residency for two (2) years following transition to the community which may be up to one (1) year following completion of the MFP participation period, or until the member is no longer enrolled in the CONTRACTOR's health plan.
- 2.9.8.4.12 The CONTRACTOR shall, using a template provided by TENNCARE, issue a written notice of MFP participation to each member enrolled in MFP which shall not occur prior to transition from CHOICES Group 1 to CHOICES Group 2. Such notice shall be issued within ten (10) business days of notification from TENNCARE via

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the outbound 834 enrollment file furnished by TENNCARE to the CONTRACTOR that the member is enrolled in MFP.

2.9.8.4.13 The CONTRACTOR shall, using a template provided by TENNCARE, issue a written notice to each member upon conclusion of the 365-day participation period. Such notice shall be issued within ten (10) business days of notification from TENNCARE via the outbound 834 enrollment file furnished by TENNCARE to the CONTRACTOR that the member is no longer enrolled in MFP.

2.9.8.4.14 A member who successfully completes 365-day participation period for MFP and is subsequently re-institutionalized may qualify to participate in MFP again but must first meet the "Eligible Individual" criteria. There shall be a minimum of ninety (90) days between MFP participation occurrences. Prior to enrollment in a second MFP occurrence, the care coordinator shall assess the reason for the re-institutionalization to determine if the member is an appropriate candidate for re-enrollment in MFP and if so, shall develop a plan of care (including a Risk Agreement) that will help to ensure that appropriate supports and services are in place to support successful transition and permanency in the community.

2.9.8.5 Plan of Care

2.9.8.5.1 For members participating in the MFP, the Plan of Care shall reflect that the member is an MFP participant, including the date of enrollment into MFP (i.e., date of transition from CHOICES Group 1 to CHOICES Group 2).

2.9.8.5.2 Upon conclusion of the member's 365-day participation period in MFP, the Plan of Care shall be updated to reflect that he is longer participating in MFP.

2.9.8.6 Services

2.9.8.6.1 A member enrolled in MFP shall be simultaneously enrolled in CHOICES Group 2 and shall be eligible to receive covered benefits as described in 2.6.1.

2.9.8.7 Continuity of Care

2.9.8.7.1 Upon completion of a person's 365-day participation in MFP, services (including CHOICES HCBS) shall continue to be provided in accordance with the covered benefits described in 2.6.1 and the member's plan of care. Transition from participation in MFP and CHOICES Group 2 to participation only in CHOICES Group 2 shall be seamless to the member, except that the CONTRACTOR shall be required to issue notice of the member's conclusion of his 365-day MFP participation period.

2.9.8.8 Short-Term Nursing Facility Stay

2.9.8.8.1 A CHOICES Group 2 member may be admitted for an inpatient short-term nursing facility stay for up to ninety (90) days and remain enrolled in CHOICES Group 2 (see Section 2.6.1.5.4). The CONTRACTOR shall ensure that the member is transitioned

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from Group 2 to Group 1 at any time: a) it is determined that the stay will not be short-term and the member will not transition back to the community; and b) prior to exhausting the ninety (90) day short-term nursing facility benefit covered for CHOICES Group 2 members (see Section 2.9.6.8.23.4).

- 2.9.8.8.2 A CHOICES Group 2 member participating in MFP may be admitted for an inpatient short-term nursing facility stay during his 365-day participation period and remain enrolled in MFP regardless of the number of days the member is admitted for inpatient facility care.
- 2.9.8.8.3 MFP participants admitted for short-term nursing facility stays shall be re-instated in MFP upon discharge and return to a Qualified Residence in the community. The member is not required to meet the ninety (90) day residency requirement criteria for re-instatement into MFP.
- 2.9.8.8.4 If the short-term stay will exceed ninety (90) days, the CONTRACTOR shall facilitate transition from CHOICES Group 2 to CHOICES Group 1.
- 2.9.8.8.5 The member's care coordinator shall monitor the member's inpatient stay and shall visit the member face-to-face at least monthly during the inpatient stay or more frequently as necessary to facilitate timely and appropriate discharge planning.
- 2.9.8.8.6 The CONTRACTOR shall conduct a Transition Assessment and develop a Transition Plan (see Section 2.9.6.8) as necessary to facilitate the member's return to the community. Such assessment shall include a review of the circumstances which resulted in the nursing facility admission and shall evaluate whether the services and supports provided to the member are sufficient to safely meet his needs in the community such that transition back to CHOICES Group 2 and continued participation in MFP is appropriate. The CONTRACTOR shall update the member's plan of care, including the member's Risk Agreement, as deemed necessary based on the member's needs and circumstances.
- 2.9.8.8.7 Upon discharge from the short-term stay, within one (1) business day, the care coordinator shall visit the member in his/her Qualified Residence. During the ninety (90) days following transition and re-instatement into MFP, the care coordinator shall conduct monthly face-to-face in-home visits to ensure that the plan of care is being followed, that the plan of care continues to meet the member's needs, and the member has successfully transitioned back to the community.
- 2.9.8.8.8 MFP participants admitted for short-term nursing facility stays shall be re-instated in MFP upon discharge and return to a Qualified Residence in the community. The member is not required to meet the ninety (90) day residency requirement criteria for re-instatement into MFP.
- 2.9.8.8.9 Days that are spent in an inpatient facility, including short-term nursing facility stays, do not count as part of the member's 365-day MFP participation period.

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2.9.8.9 TPAES

2.9.8.9.1 The CONTRACTOR shall use the TENNCARE PreAdmission Evaluation System (TPAES) to facilitate enrollments into and transitions between LTC programs, including CHOICES and the State's MFP Rebalancing Demonstration (MFP), and shall comply with all data collection processes and timelines established by TENNCARE in policy or protocol in order to gather data required to comply with tracking and reporting requirements pertaining to MFP. This shall include (but is not limited to) attestations pertaining to Eligible Individual and Qualified Residence, changes of residence, inpatient facility admissions and discharges, reasons for re-institutionalization, and reasons for disenrollment from MFP.

2.9.8.10 IT requirements

2.9.8.10.1 Pursuant to Section 2.23 of this Agreement, the CONTRACTOR shall modify its information systems to accommodate, accept, load, utilize and facilitate accurate and timely reporting on information submitted to by TENNCARE via the outbound 834 file that will identify MFP participants, as well as those MFP participants in suspended status during an inpatient admission.

2.9.8.11 Case Management System

2.9.8.11.1 The CONTRACTOR's case management system (see Section 2.9.6.12.6) shall identify persons enrolled in MFP and shall generate reports and management tools as needed to facilitate and monitor compliance with contract requirements and timelines.

2.9.8.12 MFP Readiness Review

2.9.8.12.1 Prior to implementation of MFP, as determined by TENNCARE, the CONTRACTOR shall demonstrate to TENNCARE's satisfaction that the CONTRACTOR is able to meet all of the requirements pertaining to MFP set forth in this Agreement.

2.9.8.12.2 The CONTRACTOR shall cooperate in a "readiness review" conducted by TENNCARE to review the CONTRACTOR's readiness to fulfill its obligations regarding MFP in accordance with the Agreement. This review may include, but is not limited to, desk and on-site review of documents provided by the CONTRACTOR, a walk-through of the CONTRACTOR's operations, system demonstrations (including systems connectivity testing), and interviews with CONTRACTOR's staff. The scope of the review may include any and all MFP requirements of the Agreement as determined by TENNCARE.

2.9.8.12.3 Based on the results of the review activities, TENNCARE will issue a letter of findings and, if needed, will request a corrective action plan from the CONTRACTOR.

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2.9.8.13 MFP Benchmarks

2.9.8.13.1 The CONTRACTOR shall assist TENNCARE in meeting the five (5) annual benchmarks established for the MFP Rebalancing Demonstration which are described below in Sections 2.9.8.13.1.1 through 2.9.8.13.1.5.

2.9.8.13.1.1 *Benchmark # 1: Number of Persons Transitioned*

2.9.8.13.1.1.1 Assist the projected number of eligible individuals in each target group in successfully transitioning from an inpatient facility to a qualified residence during each year of the demonstration. Projected numbers:

Calendar Year	# of Elderly Transitioned	# of Disabled Adults Transitioned
2011	27	23
2012	206	169
2013	261	214
2014	261	214
2015	234	191
2016	206	169

2.9.8.13.1.1.2 Immediately prior to implementation of MFP and at the beginning of each calendar year thereafter, statewide calendar year numbers for benchmark #1 will be allocated on a regional basis to each MCO operating in the region, based on the number of persons in CHOICES Group 1. For purposes of incentive payments (see Section 3.11), achievement of this benchmark shall be determined on a regional basis by MCO.

2.9.8.13.1.2 *Benchmark #2: Qualified Expenditures for HCBS*

2.9.8.13.1.2.1 Increase the amount and percentage of Medicaid spending for qualified home and community based long-term care services during each year of the demonstration.

2.9.8.13.1.2.2 For purposes of incentive payments (see Section 3.11), achievement of this benchmark shall be determined on a statewide basis.

2.9.8.13.1.3 *Benchmark #3: Increased Amount and Percentage of HCBS Participants*

2.9.8.13.1.3.1 Increase the number and percentage of individuals who are elderly and adults with physical disabilities receiving Medicaid-reimbursed long-term care services in home and community based (versus institutional) settings during each year of the demonstration.

2.9.8.13.1.3.2 For purposes of incentive payments (see Section 3.11), achievement of this benchmark shall be determined on a regional basis by MCO.

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2.9.8.13.1.4 *Benchmark #4: Increase Unduplicated Contracted Community Based Residential Alternative*

2.9.8.13.1.4.1 Increase the number of unduplicated licensed CBRA's contracted with MCOs Statewide to provide HCBS in the CHOICES program during each year of the demonstration. Providers enrolled with more than one (MCO) or in more than one region shall only be counted once. Proposed numbers:

Calendar Year	# of MCO Contracted CBRA's Statewide
2011	70
2012	74
2013	78
2014	82
2015	86
2016	90

2.9.8.13.1.4.2 For purposes of incentive payments (See Section 3.11), achievement of this benchmark shall be determined on a statewide basis.

2.9.8.13.1.5 *Benchmark #5: Increase Participation in Consumer Direction*

2.9.8.13.1.5.1 Increase the number of persons receiving Medicaid-reimbursed HCBS participating in consumer direction for some or all services during each year of the demonstration. Projected numbers:

Calendar Year	# in Consumer Direction
2011	450
2012	750
2013	1,000
2014	1,250
2015	1,400
2016	1,500

2.9.8.13.1.5.2 Immediately prior to implementation of MFP and at the beginning of each calendar year thereafter, statewide calendar year numbers for benchmark #5 will be allocated on a regional basis to each MCO operating in the region, based on the number of persons in CHOICES Group 2. For purposes of incentive payments (see Section 3.11), achievement of this benchmark shall be determined on a regional basis by MCO.

16. Section 2.18.6.5 shall be deleted and replaced as follows:

2.18.6.5 The CONTRACTOR shall develop and implement a training plan to educate long-term care providers regarding compliance with all Version 5010 and ICD-10 coding requirements;

17. Section 2.21.4.1.4 shall be amended by deleting obsolete references and shall read as follows:

2.21.4.1.4 The claims specified in Section 2.21.4.1.3 shall be paid at the time presented for payment by the provider and the CONTRACTOR shall bill the responsible third party.

18. The introductory paragraph of Section 2.30.6.4 shall be deleted and replaced as follows:

2.30.6.4 The CONTRACTOR shall submit a quarterly *CHOICES Nursing Facility to Community Transition Report*. Upon notification from TENNCARE, MFP participants (see 2.9.6.8) shall be identified separately for each data element described herein. The report shall include information, by month, on specified measures, which shall include but not be limited to the following:

19. The introductory paragraph of Section 2.30.6.5 shall be deleted and replaced as follows:

2.30.6.5 Upon enrollment of CHOICES Group 2 or 3 members (if and when directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3), the CONTRACTOR shall submit a monthly *CHOICES HCBS Late and Missed Visits Report* for CHOICES members regarding the following CHOICES HCBS: personal care, attendant care, homemaker services, and home-delivered meals. The report shall include information on specified measures, which shall include but not be limited to the following:

20. The introductory paragraph of Section 2.30.6.6 shall be deleted and replaced as follows:

2.30.6.6 Upon enrollment of CHOICES Group 2 or 3 members (if and when directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3), the CONTRACTOR shall submit a quarterly CHOICES Consumer Direction of HCBS Report. MFP participants (see 2.9.6.8) shall be identified separately for each data element described herein. The report shall include current information, by month, on specified measures, which shall include but not be limited to the following:

21. Section 2.30.6.6 shall be amended by adding a new Item (9) as follows:

- (9) The total number and the name, SSN, and phone number, and the authorized representative name and phone number, if applicable, of each member referred to the FEA (for enrollment into consumer direction) that has indicated on his Consumer Direction Participation Form that he does not wish to receive HCBS from contract providers pending enrollment into consumer direction, including the member's date of enrollment in CHOICES Group 2, the date of referral to the FEA for consumer direction, and the total number of days that HCBS have not been received by each member.

22. Section 2.30.6 shall be amended by adding a new Section 2.30.6.8 and renumbering the remaining Sections accordingly, including any references thereto.

2.30.6.8 Upon notification from TENNCARE, the CONTRACTOR shall submit a quarterly ~~MFP Participants Report~~. The report shall include information on specified measures, which shall include but not be limited to the following:

- (1) The total number and the name and SSN of each CHOICES Group 2 member enrolled into MFP;
- (2) The date of each member's transition to the community (or for persons enrolled in MFP upon enrollment to the CONTRACTOR's health plan, the date of enrollment into the CONTRACTOR's health plan);
- (3) Each member's current place of residence including physical address and type of Qualified Residence;
- (4) The date of the last care coordination visit to each member;
- (5) Any inpatient facility stays during the quarter, including the member's name and SSN type of Qualified Institution, dates of admission and discharge, and the reason for admission; and
- (6) The total number and name and SSN of each member disenrolled from MFP during the quarter, including the reason for disenrollment.

The CONTRACTOR shall submit its first report following the end of calendar year 2011.

23. Section 2.30.10.5 shall be deleted and replaced as follows:

2.30.10.5 The CONTRACTOR shall submit a monthly *CHOICES Utilization Report*. Upon notification from TENNCARE, MFP participants (see 2.9.6.8) shall be identified separately for each data element described herein. The report shall be submitted on a monthly basis with a one (1) month lag period (e.g., March information sent in the May report) and shall include a summary overview that includes the number of CHOICES member who have not received any long-term care services within thirty (30) to fifty-nine (59) days, within sixty (60) to eighty-nine (89) days, or in ninety (90) days or more. The report shall also include detailed member data for members who have not received services in the last thirty (30) days, including the member's name, social security number, CHOICES group, and CHOICES enrollment date; date of last long-term care service; length of time without long-term care services; whether and when long-term care services will resume; and the reason/explanation why the member has not received long-term care services.

24. Section 2.30.10.6 shall be deleted in its entirety and the remaining Sections shall be renumbered accordingly, including any references thereto.

25. The introductory paragraph of Section 2.30.11.6 shall be deleted and replaced as follows:

2.30.11.6 Upon enrollment of members in CHOICES Group 2 and/or 3 (if and when directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3), the CONTRACTOR shall submit a quarterly CHOICES HCBS Critical Incidents Report (see Section 2.15.7). MFP participants (see 2.9.6.8) shall be identified separately for each data element described herein. The report shall provide information, by month regarding specified measures, which shall include but not be limited to the following:

26. The introductory paragraph of Section 2.30.16.4 shall be deleted and replaced as follows:

2.30.16.4 Upon enrollment of members in CHOICES Group 2 and/or 3 (if and when directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3), the CONTRACTOR shall submit a quarterly CHOICES Cost Effective Alternative Services Report that provides information on cost effective alternative services provided to CHOICES members (see Section 2.6.5.2). MFP participants (see 2.9.6.8) shall be identified separately for each data element described herein. The report shall provide information regarding specified measures, including but not limited to the following:

27. The liquidated damage chart in Section 5.20.2.2.7 shall be amended by adding new damages A.27 through A.30 as follows:

A.27	Failure to process a transition referral, including completion of a face-to-face transition screening and assessment and development of a transition plan timely and in accordance with 2.9.6.8 and TENNCARE policy and protocols	\$500 per occurrence
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<p>A.28</p>	<p>Failure to initiate CHOICES HCBS or for children under age 21, EPSDT benefits provided as an alternative to nursing facility care in accordance with the member's plan of care and to ensure that such HCBS or EPSDT benefits are in place immediately upon transition from a nursing facility to the community for any person transitioning from a nursing facility (i.e., CHOICES Group 1) to the community (i.e., CHOICES Group 2), including persons enrolled in MFP (see Sections 2.9.5.4.1.5 and 2.9.6.8.16)</p>	<p>\$500 per day for each day that HCBS are not in place following transition from a nursing facility (i.e., CHOICES Group 1) to the community (i.e., CHOICES Group 2) in addition to the cost of services not provided</p>
<p>A.29</p>	<p>Failure to complete in a timely manner minimum care coordination contacts required for persons transitioned from a nursing facility to CHOICES Group 2, including post-discharge and following a significant change in circumstances (see Sections 2.9.6 and 2.9.8)</p>	<p>\$500 per occurrence</p>

<p>A.30</p>	<p>Failure to submit complete and accurate data into TPAES pertaining to MFP, or to comply with all data collection processes and timelines established by TENNCARE in policy or protocol in order to gather data required to comply with tracking and reporting requirements pertaining to MFP. This shall include (but is not limited to) attestations pertaining to Eligible Individual and Qualified Residence, changes of residence, inpatient facility admissions and discharges, reasons for re-institutionalization, and reasons for disenrollment from MFP.</p>	<p>\$500 per occurrence</p>
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29. Attachment I shall be deleted and replaced in its entirety as follows:

**ATTACHMENT I
BEHAVIORAL HEALTH SPECIALIZED SERVICE DESCRIPTIONS**

The CONTRACTOR shall provide medically necessary mental health case management and psychiatric rehabilitation services according to the requirements herein.

All behavioral health services shall be rendered in a manner that supports the recovery of persons experiencing mental illness and enhance the development of resiliency of children and families who are impacted by mental illness, serious emotional disturbance, and/or substance abuse issues. Recovery is a consumer driven process in which consumers are able to work, learn and participate fully in their communities. Recovery is the ability to live a fulfilling and productive life [with] a disability.

SERVICE	Mental Health Case Management
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DEFINITION

Mental health case management is a supportive service provided to enhance treatment effectiveness and outcomes with the goal of maximizing resilience and recovery options and natural supports for the individual. Mental health case management is consumer-centered, consumer focused and strength-based,

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with services provided in a timely, appropriate, effective, efficient and coordinated fashion. It consists of activities performed by a team or a single mental health case manager to support clinical services. Mental health case managers assist in ensuring the individual/family access to services.

Mental health case management requires that the mental health case manager and the individual and/or family have a strong productive relationship which includes viewing the individual/family as a responsible partner in identifying and obtaining the necessary services and resources. Services rendered to children and youth shall be consumer-centered and family-focused with case managers working with multiple systems (e.g. education, child welfare, juvenile justice). Mental health case management is provided in community settings, which are accessible and comfortable to the individual/family. The service should be rendered in a culturally competent manner and be outcome driven. Mental health case management shall be available 24 hours a day, 7 days a week. The service is not time limited and provides the individual/family the opportunity to improve their quality of life.

The CONTRACTOR shall ensure mental health case management is rendered in accordance with all of the service components and guidelines herein.

SERVICE DELIVERY

The CONTRACTOR shall:

- Determine caseload size based on an average number of individuals per case manager, with the expectation being that case managers will have mixed caseloads of clients and flexibility between Levels 1 and 2 (Levels 1 and 2 are defined below); and
- Ensure that caseload sizes and minimum contacts are met as follows:

Case Management Type	Maximum Caseload Size	Minimum Face-to-Face Contacts
Level 1 (Non-Team Approach)*	25 individuals:1 case manager	One (1) contact per week
Level 1 (Team Approaches):		
Adult CTT	20 individuals:1 team 20 individuals:1 case manager	One (1) contact per week
Children & Youth (C&Y) CTT	15 individuals:1 team 15 individuals:1 case manager	One (1) contact per week
CCFT	15 individuals:1 team 15 individuals:1 case manager	One (1) contact per week
ACT	100 individuals:1 team 15 individuals:1 case manager	One (1) contact per week
PACT	100 individuals:1 team 15 individuals:1 case manager	One (1) contact per week
Level 2*	35 individuals:1 case manager	Two (2) contacts per month

*For case managers having a combination of Level 1 & Level 2 (non-team) individuals, the maximum caseload size shall be no more than 30 individuals:1 case manager.

The CONTRACTOR shall ensure that the following requirements are met:

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- 1) All mental health case managers shall have, at a minimum, a bachelor's degree or be licensed as a Registered Nurse;
- 2) Supervisors shall maintain no greater than a 1:30 supervisory ratio with mental health case managers;
- 3) Mental health case managers who are assigned to both a parent(s) and child in the same family, should have skills and experience needed for both ages; mental health case managers who are assigned to individuals with co-occurring disorders (mental illness and substance abuse disorders) should have the skills and experience to meet the needs of these individuals;
- 4) Fifty-one percent (51%) of all mental health case management services should take place outside the case manager's office;
- 5) The children and youth (C&Y) (under age eighteen (18)) mental health case management model shall provide a transition from C&Y services into adult services, including adult mental health case management services. The decision to serve an 18-year old youth via the C&Y case management system versus the adult system shall be a clinical one made by a provider. Transition from children's services, including mental health case management, shall be incorporated into the child's treatment plan; and
- 6) All mental health case management services shall be documented in a treatment plan. Mental health case management activities are correlated to expected outcomes and outcome achievement and shall be monitored, with progress being noted periodically in a written record.

Level 1

Level 1 mental health case management is the most intense level of service. It provides frequent and comprehensive support to individuals with a focus on recovery and resilience. The CONTRACTOR shall ensure the provision of level 1 mental health case management to the most severely disabled adults and emotionally disturbed children and youth, including individuals who are at high risk of future hospitalization or placement out of the home and require both community support and treatment interventions. Level 1 mental health case management can be rendered through a team approach or by individual mental health case managers. Team approaches may include such models as ACT, CTT, CCFT and PACT, as described below:

Assertive Community Treatment (ACT)

ACT is a way of delivering comprehensive and effective services to adults diagnosed with severe mental illness and who have needs that have not been well met by traditional approaches to delivering services. The principles of ACT include:

- 1) Services targeted to a specific group of individuals with severe mental illness;
- 2) Treatment, support and rehabilitation services provided directly by the ACT team;
- 3) Sharing of responsibility between team members and individuals served by the team;
- 4) Small staff (all team staff including case managers) to individual ratios (approx. 1 to 10);
- 5) Comprehensive and flexible range of treatment and services;
- 6) Interventions occurring in community settings rather than in hospitals or clinic settings;
- 7) No arbitrary time limit on receiving services;
- 8) Individualized treatment, support and rehabilitation services;
- 9) Twenty-four (24) hour a day availability of services; and
- 10) Engagement of individuals in treatment and monitoring.

Continuous Treatment Team (CTT)

CTT is a coordinated team of staff (to include physicians, nurses, case managers, and other therapists as needed) who provide a range of intensive, integrated mental health case management, treatment, and rehabilitation services to adults and children and youth. The intent is to provide intensive treatment to families of children and youth with acute psychiatric problems in an effort to prevent removal from the home to a more restrictive level of care. An array of services are delivered in the home or in natural settings in the community, and are provided through a strong partnership with the family and other community support systems. The program provides services including crisis intervention and stabilization, counseling, skills building, therapeutic intervention, advocacy, educational services, medication management as indicated, school based counseling and consultation with teachers, and other specialized services deemed necessary and appropriate.

Comprehensive Child and Family Treatment (CCFT)

CCFT services are high intensity, time-limited services designed for children and youth to provide stabilization and deter the “imminent” risk of State custody for the individual. There is usually family instability and high-risk behaviors exhibited by the child/adolescent. CCFT services are concentrated on child, family, and parental/guardian behaviors and interaction. CCFT services are more treatment oriented and situation specific with a focus on short-term stabilization goals. The primary goal of CCFT is to reach an appropriate point of stabilization so the individual can be transitioned to a less intense outpatient service.

Program of Assertive and Community Treatment (PACT)

PACT is a service delivery model for providing comprehensive community-based treatment to adults with severe and persistent mental illness. It involves the use of a multi-disciplinary team of mental health staff organized as an accountable, mobile mental health agency or group of providers who function as a team interchangeably to provide the treatment, rehabilitation and support services persons with severe and/or persistent mental illnesses need to live successfully in the community.

Level 2

Level 2 mental health case management is a less intensive level of service than Level 1 and is focused on resilience and recovery. The CONTRACTOR shall ensure that level 2 mental health case management is provided to individuals whose symptoms are at least partially stabilized or reduced in order to allow treatment and rehabilitation efforts.

SERVICE COMPONENTS

The CONTRACTOR shall ensure that mental health case management incorporates the following service components:

Crisis Facilitation

Crisis facilitation is provided in situations requiring immediate attention/resolution for a specific individual or other person(s) in relation to a specific individual. It is the process of accessing and coordinating services for an individual in a crisis situation to ensure the necessary services are rendered during and following the crisis episode. Most crisis facilitation activities would involve face-to-face contact with the individual.

Assessment of Daily Functioning

Assessment of daily functioning involves the on-going monitoring of how an individual is coping with life on a day to day basis for the purposes of determining necessary services to maintain community placement and improve level of functioning. Most assessments of daily functioning are achieved by face-to-face contact with the individual in his or her natural environment.

Assessment/Referral/Coordination

Assessment/referral/coordination involves assessing the needs of the individual for the purposes of referral and coordination of services that will improve functioning and/or maintain stability in the individual's natural environment.

Mental Health Liaison

Mental health liaison services are offered to persons who are not yet assigned to mental health case management. It is a short-term service for the purposes of service referral and continuing care until other mental health services are initiated.

SERVICE	Psychiatric Rehabilitation
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DEFINITION

Psychiatric rehabilitation is an array of consumer-centered recovery services designed to support the individual in the attainment or maintenance of his or her optimal level of functioning. These services are designed to capitalize on personal strengths, develop coping skills and strategies to deal with deficits and develop a supportive environment in which to function as independent as possible on the individual's recovery journey.

Services included under psychiatric rehabilitation are as follows.

SERVICE COMPONENTS

Psychosocial Rehabilitation

Psychosocial rehabilitation services utilize a comprehensive approach (mind, body, and spirit) to work with the whole person for the purposes of improving an individuals' functioning, promoting management of illness(s), and facilitating recovery. The goal of psychosocial rehabilitation is to support individuals as active and productive members of their communities. Individuals, in partnership with staff, form goals for skills development in the areas of vocational, educational, and interpersonal growth (e.g. household management, development of social support networks) that serve to maximize opportunities for successful community integration. Individuals proceed toward goal attainment at their own pace and may continue in the program at varying levels intensity for an indefinite period of time.

Supported Employment

Supported employment consists of a range of services to assist individuals to choose, prepare for, obtain, and maintain gainful employment that is based on individuals' preferences, strengths, and experiences. This service also includes a variety of support services to the individual, including side-by-side support on the job. These services may be integrated into a psychosocial rehabilitation center.

Peer Support

Peer support services allow individuals to direct their own recovery and advocacy process and are provided by persons who are or have been consumers of the behavioral health system and their family members and are Certified Peer Support Specialists. A Certified Peer Support Specialist is a person who has identified himself or herself as having received or is receiving mental health or co-occurring disorder services in his or her personal recovery process and has undergone training recognized by the Tennessee Department of Mental Health, Office of Consumer Affairs on how to assist peers with the recovery process.

These services include providing assistance with more effectively utilizing the service delivery system (e.g. assistance in developing plans of care, accessing services and supports, partnering with professionals) or understanding and coping with the stressors of the person's illness through support groups, coaching, role modeling, and mentoring. Activities which promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills are rendered so individuals can educate and support each other in the acquisition of skills needed to manage their illnesses and access resources within their communities. Services are often provided during the evening and weekend hours.

Illness Management & Recovery

Illness management and recovery services refers to a series of weekly sessions with trained mental health practitioners for the purpose of assisting individuals in developing personal strategies for coping with mental illness and promoting recovery. Illness management and recovery is not limited to one curriculum, but is open to all evidenced-based and/or best practice classes and programs such as WRAP (Wellness Recovery Action Plan).

Supported Housing

Supported housing services refers to services rendered at facilities that are staffed twenty-four (24) hours per day, seven (7) days a week with associated mental health staff supports for individuals who require treatment services and supports in a highly structured setting. These mental health services are for persons with serious and/or persistent mental illnesses (SPMI) and are intended to prepare individuals for more independent living in the community while providing an environment that allows individuals to live in community settings. Given this goal, every effort should be made to place individuals in facilities near their families and other support systems and original areas of residence. Supported housing services are mental health services and do not include the payment of room and board.

SERVICE	Crisis Services
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Definition

Behavioral health crisis services shall be rendered to individuals with a mental health or substance use/abuse issue when there is a perception of a crisis by an individual, family member, law enforcement, hospital staff or others who have closely observed the individual experiencing the crisis. Crisis services are available twenty-four (24) hours a day, seven (7) days a week. Crisis services include twenty-four (24) hour toll free telephone lines answered in real time by trained crisis specialists and face-to-face crisis services including, but not limited to: prevention, triage, intervention, evaluation/referral for additional services/treatment, and follow-up services. Peer support specialists shall be utilized in conjunction with crisis specialists to assist adults in alleviating and stabilizing crises and promote the recovery process as

Amendment 26 (cont.)

appropriate. Behavioral health crisis service providers are not responsible for pre-authorizing emergency involuntary hospitalizations.

The Mental Health Crisis Response Services - Community Face-to-Face Response Protocols provide guidance for calls that are the responsibility of a crisis response service to determine if a Face-to-Face evaluation is warranted and those that are not the responsibility of the crisis response service. These Protocols were developed to ensure that consumers who are experiencing a behavioral health crisis and have no other resources receive prompt attention. All responses are first determined by clinical judgment.

Guidance for All Calls:

- For calls originating from an Emergency Dept., telehealth is the preferred service delivery method for the crisis response service
- After determining that there is no immediate harm, ask the person if he or she can come to the closest walk-in center
- If a Mandatory Pre-screening Agent (MPA) not employed by a crisis response service is available, there may be no need for a crisis evaluation by mobile crisis
- For all other calls, unless specified in the Protocols, if a person with mental illness is experiencing the likelihood of immediate harm then a response is indicated.

Amendment 26 (cont.)

All of the provisions of the original Agreement not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective October 1, 2011.

The CONTRACTOR, by signature of this Amendment, hereby affirms that this Amendment has not been altered and therefore represents the identical document that was sent to the CONTRACTOR by TENNCARE.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

BY: Mark A. Emkes
Mark Emkes
Commissioner

DATE: 9/21/2011

VOLUNTEER STATE HEALTH PLAN, INC.

BY: J. D. Hickey
J. D. Hickey
SVP President & CEO VSHIP

DATE: _____

APPROVED BY:

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

BY: Mark A. Emkes
Mark Emkes
Commissioner

DATE: 9/27/11

APPROVED BY:

**STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY**

BY: Justin P. Wilson
Justin P. Wilson
Comptroller

DATE: 10/10/11

CONTRACT NOT PAID THROUGH EDISON

CONTRACT SUMMARY SHEET

RFS Number:	318.66-026	Contract Number:	FA-02-14632-25
State Agency:	Department of Finance and Administration	Division:	Bureau of TennCare
Contractor		Contract Identification Number	
VSHP (TennCare Select)		<input type="checkbox"/> V-	<input type="checkbox"/> C-

Service Description

Managed Care Organization / Medically Necessary Health Care Services to the TennCare

Contract Begin Date

7/1/2001

Contract End Date

6/30/2012

Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66	4A2	134	11	<input type="checkbox"/> STARS		
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)	
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$ 18,599,868.48	
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$ 33,079,942.80	
2004	\$ 25,125,990.72	\$ 38,364,165.90			\$ 63,490,156.62	
2005	\$ 58,007,447.00	\$ 58,007,447.00			\$ 116,014,894.00	
2006	\$87,748,111.00	\$87,748,111.00			\$175,496,222.00	
2007	\$87,748,111.00	\$87,748,111.00			\$175,496,222.00	
2008	\$72,610,000.00	\$127,390,000.00			\$200,000,000.00	
2009	\$72,610,000.00	\$127,390,000.00			\$200,000,000.00	
2010	\$100,882,479.00	\$304,024,121.00			\$404,906,600.00	
2011	\$131,085,619.00	\$312,820,981.00			\$443,906,600.00	
2012	\$149,893,942.00	\$294,012,658.00			\$443,906,600.00	
Total:	\$ 808,252,760.35	\$ 1,466,644,345.55			\$2,274,897,105.90	

OCR RECEIVED
JUN 03 2011
TO AGENCY

CFDA#	93.778 Title XIX Dept. of Health & Human Svcs.	Check the box ONLY if the answer is YES:	
State Fiscal Contract		Is the Contractor a SUBRECIPIENT? (per OMB A-133)	<input type="checkbox"/>
Name:	Scott Pierce	Is the Contractor a Vendor? (per OMB A-133)	<input type="checkbox"/>
Address:	310 Great Circle Road	Is the Fiscal Year Funding STRICTLY LIMITED?	<input type="checkbox"/>
Phone:	Nashville, TN (615)507-6415	Is the Contractor on STARS?	<input type="checkbox"/>
Procuring Agency Budget Officer Approval Signature		Is the Contractor's FORM W-9 ATTACHED?	<input type="checkbox"/>
Scott Pierce		Is the Contractor's Form W-9 Filed with Accounts?	<input type="checkbox"/>

COMPLETE FOR ALL AMENDMENTS (only)			Funding Certification
	Base Contract & Prior Amendments	This Amendment ONLY	Pursuant to T.C.A., Section 9-6-113, I. M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.
CONTRACT END DATE:	6/30/2011	6/30/2012	
FY: 2002	\$ 18,599,868.48		
FY: 2003	\$ 33,079,942.80		
FY: 2004	\$ 63,490,156.62		
FY: 2005	\$116,014,894.00		
FY: 2006	\$175,496,222.00		
FY: 2007	\$175,151,878.00		
FY: 2008	\$200,000,000.00		
FY: 2009	\$200,000,000.00		
FY: 2010	\$404,906,600.00		
FY: 2011	\$443,906,600.00	\$443,906,600.00	
FY: 2012		\$443,906,600.00	
Total:	\$1,830,990,505.90	\$443,906,600.00	

OCR
JUN 03 2011
RECEIVED

**AMENDMENT NUMBER 25
AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.**

CONTRACT NUMBER: FA-02-14632-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as specified below.

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. Section 1 shall be amended by deleting and replacing the following definitions:

Back-up Plan – A written plan that is a required component of the plan of care for all CHOICES members receiving companion care or non-residential CHOICES HCBS in their own home and which specifies unpaid persons as well as paid consumer-directed workers and/or contract providers (as applicable) who are available, have agreed to serve as back-up, and who will be contacted to deliver needed care in situations when regularly scheduled CHOICES HCBS providers or workers are unavailable or do not arrive as scheduled. A CHOICES member or his/her representative may not elect, as part of the back-up plan, to go without services. The back-up plan shall include the names and telephone numbers of persons and agencies to contact and the services to be provided by each of the listed contacts. The member and his/her representative (as applicable) shall have primary responsibility for the development and implementation of the back-up plan for consumer directed services with assistance from the FEA as needed.

Care Coordination Team – If an MCO elects to use a care coordination team, the care coordination team shall consist of a care coordinator and specific other persons with relevant expertise and experience who are assigned to support the care coordinator in the performance of care coordination activities for a CHOICES member as specified in this Agreement and in accordance with Section 2.9.6., but shall not perform activities that must be performed by the Care Coordinator, including needs assessment, development of the plan of care, and minimum Care Coordination contacts.

Caregiver – For purposes of CHOICES, a person who is (a) a family member or is unrelated to the member but has a close, personal relationship with the member and (b) routinely involved in providing unpaid support and assistance to the member. A caregiver may be also designated by the member as a representative for CHOICES or for consumer direction of eligible CHOICES HCBS.

Amendment Number 25 (cont.)

CHOICES Group (Group) – One of the three groups of TennCare enrollees who are enrolled in CHOICES. There are three CHOICES groups:

1. Group 1
Medicaid enrollees of all ages who are receiving Medicaid-reimbursed care in a nursing facility.
2. Group 2
Persons age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who meet the nursing facility level of care, who qualify for TennCare either as SSI recipients or as members of the CHOICES 217-Like HCBS Group, and who need and are receiving CHOICES HCBS as an alternative to nursing facility care. The CHOICES 217-Like HCBS Group includes persons who could have been eligible under 42 CFR 435.217 had the state continued its 1915(c) HCBS waiver for elders and/or persons with physical disabilities. TENNCARE has the discretion to apply an enrollment target to this group, as described in TennCare rules and regulations.
3. Group 3
Persons age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who qualify for TennCare as SSI recipients, who do not meet the nursing facility level of care, but who, in the absence of CHOICES HCBS, are “at-risk” for nursing facility care, as defined by the State. TENNCARE has the discretion to apply an enrollment target to this group, as described in TennCare rules and regulations. Group 3 was not included in CHOICES on the date of CHOICES implementation. TENNCARE intends to include CHOICES Group 3 at such time that the State is permitted to modify nursing facility level of care based on CMS interpretation of maintenance of effort requirements set forth in the Affordable Care Act. TENNCARE will notify the CONTRACTOR at least sixty (60) days prior to the proposed date for including Group 3 in CHOICES. As of the date specified in that notice, the CONTRACTOR shall accept members in CHOICES Group 3 and shall implement all of the requirements in this Agreement that are applicable to CHOICES Group 3.

Consumer – Except when used regarding consumer direction of eligible CHOICES HCBS, an individual who uses a mental health or substance abuse service.

Consumer-Directed Worker (Worker) – An individual who has been hired by a CHOICES member participating in consumer direction of eligible CHOICES HCBS or his/her representative to provide one or more eligible CHOICES HCBS to the member. Worker does not include an employee of an agency that is being paid by an MCO to provide HCBS to the member.

Consumer Direction of Eligible CHOICES HCBS – The opportunity for a CHOICES member assessed to need specified types of CHOICES HCBS including attendant care, personal care, homemaker, in-home respite, companion care and/or any other service specified in TennCare rules and regulations as available for consumer direction to elect to direct and manage (or to have a representative direct and manage) certain aspects of the provision of such services—primarily, the hiring, firing, and day-to-day supervision of consumer-directed workers delivering the needed service(s).

Cost Neutrality Cap – The requirement that the cost of providing care to a member in CHOICES Group 2, including CHOICES HCBS and Medicaid reimbursed home health and private duty nursing, shall not exceed the cost of providing nursing facility services to the member, as

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determined in accordance with TennCare policy. A member's individual cost neutrality cap shall be the average cost of Level 1 nursing facility care unless a higher cost neutrality cap is established by TennCare based on information submitted by the AAAD or MCO (as applicable) in the PAE application.

Disenrollment – The removal of an enrollee from participation in the CONTRACTOR's MCO and deletion from the outbound 834 enrollment file furnished by TENNCARE to the CONTRACTOR.

Electronic Visit Verification (EVV) System – An electronic system into which provider staff and consumer-directed workers can check-in at the beginning and check-out at the end of each period of service delivery to monitor member receipt of specified CHOICES HCBS and which may also be utilized for submission of claims.

Eligible CHOICES HCBS – Attendant care, personal care, homemaker, in-home respite, companion care services and/or any other CHOICES HCBS specified in TennCare rules and regulations as eligible for consumer direction for which a CHOICES member is determined to need and elects to direct and manage (or have a representative direct and manage) certain aspects of the provision of such services – primarily the hiring, firing and day-to-day supervision of consumer-directed workers delivering the needed service(s). Eligible CHOICES HCBS do not include home health or private duty nursing services.

Employer of Record – The member participating in consumer direction of eligible CHOICES HCBS or a representative designated by the member to assume the consumer direction of eligible CHOICES HCBS functions on the member's behalf.

Expenditure Cap – The annual limit on expenditures for CHOICES HCBS, excluding home modifications, for CHOICES members in CHOICES Group 3. The expenditure cap is \$15,000.

Fiscal Employer Agent (FEA) – An entity contracting with the State and/or an MCO that helps CHOICES members participating in consumer direction of eligible CHOICES HCBS. The FEA provides both financial administration and supports brokerage functions for CHOICES members participating in consumer direction of eligible CHOICES HCBS. This term is used by the IRS to designate an entity operating under Section 3504 of the IRS code, Revenue Procedure 70-6 and Notice 2003-70, as the agent to members for the purpose of filing certain federal tax forms and paying federal income tax withholding, FICA and FUTA taxes. The FEA also files state income tax withholding and unemployment insurance tax forms and pays the associated taxes and processes payroll based on the eligible CHOICES HCBS authorized and provided.

Home and Community-Based Services (HCBS) – Services that are provided pursuant to a Section 1915(c) waiver or the CHOICES program as an alternative to long-term care institutional services in a nursing facility or an Intermediate Care Facility for the Mentally Retarded (ICF/MR). HCBS may also include optional or mandatory services that are covered by Tennessee's Title XIX state plan or under the TennCare demonstration for all eligible enrollees, including home health or private duty nursing. However, only CHOICES HCBS are eligible for Consumer Direction. CHOICES HCBS do not include home health or private duty nursing services or any other HCBS that are covered by Tennessee's Title XIX state plan or under the TennCare demonstration for all eligible enrollees, although such services are subject to estate recovery and shall be counted for purposes of determining whether a CHOICES member's needs can be safely met in the community within his or her individual cost neutrality cap.

Amendment Number 25 (cont.)

Immediate Eligibility – A mechanism by which the State can, based on a preliminary determination of a person’s eligibility for the CHOICES 217-Like HCBS Group, enroll the person into CHOICES Group 2 and provide immediate access to a limited package of CHOICES HCBS pending a final determination of eligibility. To qualify for immediate eligibility, a person must be applying to receive covered ongoing CHOICES HCBS, be determined by TENNCARE to meet nursing facility level of care, have submitted an application for financial eligibility determination to DHS, and be expected to qualify for CHOICES Group 2 based on review of the financial information provided by the applicant. Immediate eligibility shall only be for specified CHOICES HCBS (no other covered services) and for a maximum of forty-five (45) days from the effective date of eligibility.

One-Time CHOICES HCBS – Specified CHOICES HCBS which occur as a distinct event or which may be episodic in nature (occurring at less frequent irregular intervals or on an as needed basis for a limited duration of time). One-time HCBS include in-home respite, in-patient respite, assistive technology, minor home modifications, and/or pest control.

Ongoing CHOICES HCBS – Specified CHOICES HCBS which are delivered on a regular and ongoing basis, generally one or more times each week, or (in the case of community-based residential alternatives and PERS) on a continuous basis. Ongoing HCBS include community-based residential alternatives, personal care, attendant care, homemaker services, home-delivered meals, personal emergency response systems (PERS), and/or adult day care.

Representative – In general, for CHOICES members, a person who is at least eighteen (18) years of age and is authorized by the member to participate in care planning and implementation and to speak and make decisions on the member’s behalf, including but not limited to identification of needs, preference regarding services and service delivery settings, and communication and resolution of complaints and concerns. As it relates to consumer direction of eligible CHOICES HCBS, a person who is authorized by the member to direct and manage the member’s worker(s), and signs a representative agreement. The representative for consumer direction of eligible CHOICES HCBS must also: be at least eighteen (18) years of age; have a personal relationship with the member and understand his/her support needs; know the member’s daily schedule and routine, medical and functional status, medication regimen, likes and dislikes, and strengths and weaknesses; and be physically present in the member’s residence on a regular basis or at least at a frequency necessary to supervise and evaluate workers.

Representative Agreement – The agreement between a CHOICES member electing consumer direction of eligible CHOICES HCBS who has a representative direct and manage the consumer’s worker(s) and the member’s representative that specifies the roles and responsibilities of the member and the member’s representative.

Risk Agreement – An agreement signed by a member who will receive CHOICES HCBS (or his/her representative) that includes, at a minimum, identified risks to the member of residing in the community and receiving HCBS, the possible consequences of such risks, strategies to mitigate the identified risks, and the member’s decision regarding his/her acceptance of risk. For members electing to participate in consumer direction, the risk agreement must include any additional risks associated with the member’s decision to act as the employer of record, or to have a representative act as the employer of record on his/her behalf. See Section 2.9.6 of this Agreement for related requirements.

Self-Direction of Health Care Tasks – A decision by a CHOICES member participating in consumer direction to direct and supervise a paid worker delivering eligible CHOICES HCBS in

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the performance of health care tasks that would otherwise be performed by a licensed nurse. Self-direction of health care tasks is not a service, but rather health care-related duties and functions (such as administration of medications) that a CHOICES member participating in consumer direction may elect to have performed by a consumer-directed worker as part of the delivery of eligible CHOICES HCBS s/he is authorized to receive.

Service Agreement – The agreement between a CHOICES member electing consumer direction of eligible CHOICES HCBS (or the member’s representative) and the member’s consumer-directed worker that specifies the roles and responsibilities of the member (or the member’s representative) and the member’s worker.

Service Gap – A delay in initiating any long-term care service and/or a disruption of a scheduled, ongoing CHOICES HCBS that was not initiated by a member, including late and missed visits.

Supports Broker – An individual assigned by the FEA to each CHOICES member participating in consumer direction who assists the member/representative in performing the employer of record functions, including, but not limited to: developing job descriptions; locating; recruiting; interviewing; scheduling; monitoring; and evaluating workers. The supports broker collaborates with, but does not duplicate, the functions of the member’s care coordinator. The supports broker does not have authority or responsibility for consumer direction. The member or member’s representative must retain authority and responsibility for consumer direction.

2. Section 1 shall be amended by adding the following definition:

CHOICES Home and Community-Based Services (HCBS) – Services that are available only to eligible persons enrolled in CHOICES Group 2 or Group 3 as an alternative to long-term care institutional services in a nursing facility or to delay or prevent placement in a nursing facility. Only CHOICES HCBS are eligible for Consumer Direction. CHOICES HCBS do not include home health or private duty nursing services or any other HCBS that are covered by Tennessee’s Title XIX state plan or under the TennCare demonstration for all eligible enrollees, although such services are subject to estate recovery and shall be counted for purposes of determining whether a CHOICES member’s needs can be safely met in the community within his or her individual cost neutrality cap.

- 3. Sections 2.4.5.1 and 2.4.5.2 shall be amended by adding the words “outbound 834” in front of the words “enrollment file”.**
- 4. Section 2.4.6.1 shall be amended by adding the words “outbound 834” in front of the words “enrollment files”.**
- 5. Section 2.4.6.2 shall be amended by adding the words “(inbound 834)” after the words “eligibility file”.**

- 6. The first sentence of the third paragraph in the Benefit Limit description for “Non-Emergency Medical Transportation (Including Non-Emergency Ambulance Transportation)” of Section 2.6.1.3 shall be amended by deleting the phrase “, including services”.**

“The CONTRACTOR is not responsible for providing NEMT to HCBS provided through a 1915(c) waiver program for persons with intellectual disabilities (i.e., mental retardation) and HCBS provided through the CHOICES program.”

- 7. Sections 2.6.1.5 through 2.6.1.5.8.5 shall be deleted and replaced as follows:**

2.6.1.5 Long-Term Care Benefits for CHOICES Members

2.6.1.5.1 In addition to physical health benefits (see Section 2.6.1.3) and behavioral health benefits (see Section 2.6.1.4), the CONTRACTOR shall provide long-term care services (including CHOICES HCBS and nursing facility care) as described in this Section 2.6.1.5 to members who have been enrolled into CHOICES by TENNCARE, as shown in the outbound 834 enrollment file furnished by TENNCARE to the CONTRACTOR, effective upon the CHOICES Implementation Date (see Section 1).

2.6.1.5.2 TennCare enrollees will be enrolled by TENNCARE into CHOICES if the following conditions, at a minimum, are met:

2.6.1.5.2.1 TENNCARE or its designee determines the enrollee meets the categorical and financial eligibility criteria for Group 1, 2 or 3;

2.6.1.5.2.2 For Groups 1 and 2, TENNCARE determines that the enrollee meets nursing facility level of care including for Group 2, that the enrollee needs ongoing CHOICES HCBS in order to live safely in the home or community setting and to delay or prevent nursing facility placement;

2.6.1.5.2.3 For Group 2, the CONTRACTOR or, for new TennCare applicants, TENNCARE or its designee, determines that the enrollee’s combined CHOICES HCBS, private duty nursing and home health care can be safely provided at a cost less than the cost of nursing facility care for the member;

2.6.1.5.2.4 For Group 3, TENNCARE determines that the enrollee meets the at-risk level of care; and

2.6.1.5.2.5 For Groups 2 and 3, if there is an enrollment target, TENNCARE determines that the enrollment target has not been met or, for Group 2, approves the CONTRACTOR’s request to provide CHOICES HCBS as a cost effective alternative (see Section 2.6.5). Enrollees transitioning from a nursing facility to the community will not be subject to the enrollment target for Group 2 but must meet categorical and financial eligibility for Group 2.

2.6.1.5.3 For persons determined to be eligible for enrollment in Group 2 as a result of Immediate Eligibility (as defined in Section 1 of this Agreement), the CONTRACTOR shall provide a limited package of CHOICES HCBS (personal care, attendant care, homemaker services, home-delivered meals, PERS, adult day care, and/or any other services as specified in

Amendment Number 25 (cont.)

TennCare rules and regulations) as identified through a needs assessment and specified in the plan of care. Upon notice that the State has determined that the member meets categorical and financial eligibility for TennCare CHOICES, the CONTRACTOR shall authorize additional services in accordance with Section 2.9.6.2.5. For members residing in a community-based residential alternative at the time of CHOICES enrollment, authorization for community-based residential alternative services shall be retroactive to the member's effective date of CHOICES enrollment.

2.6.1.5.4 The following long-term care services are available to CHOICES members, per Group, when the services have been determined medically necessary by the CONTRACTOR.

Service and Benefit Limit	Group 1	Group 2	Group 3
Nursing facility care	X	Short-term only (up to 90 days)	Short-term only (up to 90 days)
Community-based residential alternatives		X	
Personal care visits (up to 2 visits per day)		X	X
Attendant care (up to 1080 hours per calendar year)		X	X
Homemaker services (up to 3 visits per week)		X	X
Home-delivered meals (up to 1 meal per day)		X	X
Personal Emergency Response Systems (PERS)		X	X
Adult day care (up to 2080 hours per calendar year)		X	X
In-home respite care (up to 216 hours per calendar year)		X	X
In-patient respite care (up to 9 days per calendar year)		X	X
Assistive technology (up to \$900 per calendar year)		X	X
Minor home modifications (up to \$6,000 per project; \$10,000 per calendar year; and \$20,000 per lifetime)		X	X
Pest control (up to 9 units per calendar year)		X	X

Amendment Number 25 (cont.)

- 2.6.1.5.5 In addition to the benefit limits described above, in no case shall the CONTRACTOR exceed the member's individual cost neutrality cap (as defined in Section 1 of this Agreement) for CHOICES Group 2 or the expenditure cap for Group 3.
- 2.6.1.5.5.1 For CHOICES members in Group 2, the services that shall be compared against the member's individual cost neutrality cap include the total cost of CHOICES HCBS and Medicaid reimbursed home health care and private duty nursing. The total cost of CHOICES HCBS includes all covered CHOICES HCBS and other non-covered services that the CONTRACTOR elects to offer as a cost effective alternative to nursing facility care pursuant to Section 2.6.5.2 of this Agreement including, as applicable: CHOICES HCBS in excess of specified CHOICES benefit limits, the one-time transition allowance for Group 2 and NEMT for Groups 2 and 3.
- 2.6.1.5.5.2 For CHOICES members in Group 3, the total cost of CHOICES HCBS, excluding minor home modifications, shall not exceed the expenditure cap (as defined in Section 1 of this Agreement).
- 2.6.1.5.6 CHOICES members may, pursuant to Section 2.9.7, choose to participate in consumer direction of eligible CHOICES HCBS and, at a minimum, hire, fire and supervise workers of eligible CHOICES HCBS.
- 2.6.1.5.7 The CONTRACTOR shall, on an ongoing basis, monitor CHOICES members' receipt and utilization of long-term care services and identify CHOICES members who are not receiving long-term care services. Pursuant to Section 2.30.10.5, the CONTRACTOR shall, on a monthly basis, notify TENNCARE regarding members that have not received long-term care services for a thirty (30) day period of time. The CONTRACTOR shall be responsible for immediately initiating disenrollment of any member who is not receiving TennCare-reimbursed long-term care services and is not expected to resume receiving long-term care services within the next thirty (30) days, except under extenuating circumstances which must be reported to TennCare on the *CHOICES Utilization Report*. Acceptable circumstances may include, but are not limited to, a member's temporary hospitalization or temporary receipt of Medicare-reimbursed skilled nursing facility care. Such notification and/or disenrollment shall be based not only on receipt and/or payment of claims for long-term care services, but also upon review and investigation by the CONTRACTOR as needed to determine whether the member has received long-term care services, regardless of whether claims for such services have been submitted or paid.
- 2.6.1.5.8 The CONTRACTOR may submit to TENNCARE a request to no longer provide long-term care services to a member due to concerns regarding the ability to safely and effectively care for the member in the community and/or to ensure the member's health, safety and welfare. Acceptable reasons for this request include but are not limited to the following:
 - 2.6.1.5.8.1 A member in Group 2 for whom the CONTRACTOR has determined that it cannot safely and effectively meet the member's needs at a cost that is less than the member's cost neutrality cap, and the member declines to transition to a nursing facility;
 - 2.6.1.5.8.2 A member in Group 2 or 3 who repeatedly refuses to allow a care coordinator entrance into his/her place of residence (Section 2.9.6);

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- 2.6.1.5.8.3 A member in Group 2 or 3 who refuses to receive critical HCBS as identified through a needs assessment and documented in the member's plan of care; and
 - 2.6.1.5.8.4 A member in Group 1 who fails to pay his/her patient liability and the CONTRACTOR is unable to find a nursing facility willing to provide services to the member (Section 2.6.7.2).
 - 2.6.1.5.8.5 A member in Group 2 or 3 who refuses to pay his/her patient liability and for whom the CONTRACTOR is either: 1) in the case of persons receiving CBRA services, unable to identify another provider willing to provide services to the member; or 2) in the case of persons receiving non-residential HCBS or companion care, the CONTRACTOR is unwilling to continue to serve the member, and the Bureau of TennCare has determined that no other MCO is willing to serve the member.
 - 2.6.1.5.8.6 The CONTRACTOR's request to no longer provide long-term care services to a member shall include documentation as specified by TENNCARE. The State shall make any and all determinations regarding whether the CONTRACTOR may discontinue providing long-term care services to a member, disenrollment from CHOICES, and, as applicable, termination from TennCare.
 - 2.6.1.5.9 The CONTRACTOR may submit to TENNCARE a request to disenroll from CHOICES a member who is not receiving any Medicaid-reimbursed LTC services based on the CONTRACTOR's inability to reach the member only when the CONTRACTOR has exhausted all reasonable efforts to contact the member, and has documented such efforts in writing, which must be submitted with the disenrollment request. Efforts to contact the member shall include, at a minimum:
 - 2.6.1.5.9.1 Multiple attempts to contact the member, his/her representative or designee (as applicable) by phone. Such attempts must occur over a period of at least two (2) weeks and at different times of the day and evening, including after business hours. The CONTRACTOR shall attempt to contact the member at the phone number provided in the outbound 834 enrollment file, any additional phone numbers the CONTRACTOR has on file, including referral records and case management notes; and phone numbers that may be provided in TENNCARE's TPAES system. The CONTRACTOR shall also contact the member's Primary Care Provider and any contracted LTC providers that have delivered services to the member during the previous six (6) months in order to obtain contact information that can be used to reach the member;
 - 2.6.1.5.9.2 At least one (1) visit to the member's most recently reported place of residence except in circumstances where significant safety concerns prevent the CONTRACTOR from completing the visit, which shall be documented in writing; and
 - 2.6.1.5.9.3 An attempt to contact the member by mail at the member's most recently reported place of residence at least two (2) weeks prior to the request to disenroll.
- 8. Sections 2.6.5.2.1 through 2.6.5.2.3 shall be amended by inserting the word "CHOICES" before the word "HCBS".**

9. Section 2.6.5.3 shall be deleted and replaced as follows:

2.6.5.3 If the CONTRACTOR chooses to provide cost effective alternative services to a CHOICES member, in no case shall the cost of CHOICES HCBS, private duty nursing and home health care for Group 2 exceed a member's cost neutrality cap nor the total cost of CHOICES HCBS, excluding minor home modifications, for members in Group 3 exceed the expenditure cap. The total cost of CHOICES HCBS includes all covered CHOICES HCBS and other non-covered services that the CONTRACTOR elects to offer as a cost effective alternative to nursing facility care pursuant to Section 2.6.5.2 of this Agreement including, as applicable: CHOICES HCBS in excess of specified benefit limits, the one-time transition allowance for Group 2 and NEMT for Groups 2 and 3.

10. Sections 2.6.7.2 through 2.6.7.2.5 shall be deleted and replaced as follows:

2.6.7.2 Patient Liability

2.6.7.2.1 TENNCARE will notify the CONTRACTOR of any applicable patient liability amounts for CHOICES members via the outbound 834 enrollment file.

2.6.7.2.1.1 When TENNCARE notifies the CONTRACTOR of patient liability amounts for CHOICES members via the outbound 834 enrollment file with an effective date any time other than the first day of the month, the CONTRACTOR shall determine and apply the pro-rated portion of patient liability for that month.

2.6.7.2.2 The CONTRACTOR shall delegate collection of patient liability for CHOICES Group 1 members to the nursing facility and shall pay the facility net of the applicable patient liability amount.

2.6.7.2.2.1 In accordance with the involuntary discharge process, including notice and appeal (see Section 2.12.11.3), a nursing facility may refuse to continue providing services to a member who fails to pay his or her patient liability and for whom the nursing facility can demonstrate to the CONTRACTOR that it has made a good faith effort to collect payment.

2.6.7.2.2.2 If the CONTRACTOR is notified that a nursing facility is considering discharging a member (see Section 2.12.11.3), the CONTRACTOR shall work to find an alternate nursing facility willing to serve the member and document its efforts in the member's files.

2.6.7.2.2.3 If the CONTRACTOR is unable to find an alternate nursing facility willing to serve the member and the member otherwise qualifies to enroll in CHOICES Group 2, the CONTRACTOR shall determine if it can safely and effectively serve the member in the community and within the cost neutrality cap. If it can, and the CONTRACTOR is willing to continue serving a member who has failed to pay his or her patient liability or if TENNCARE determines that the member would not have patient liability in the community setting, the member shall be offered a choice of CHOICES HCBS. If the member chooses CHOICES HCBS, the CONTRACTOR shall forward all relevant information to TENNCARE for a decision regarding transition to Group 2 (Section 2.9.6.3).

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- 2.6.7.2.2.4 If the CONTRACTOR is unable to find an alternate nursing facility willing to serve the member and the CONTRACTOR determines that it cannot safely and effectively serve the member in the community and within the cost neutrality cap, the member declines to enroll in Group 2, or TENNCARE determines that the member would continue to have patient liability in the community setting and the CONTRACTOR is unwilling to continue serving the member who has failed to pay his or her patient liability, or TENNCARE denies enrollment in Group 2, the CONTRACTOR may, pursuant to Section 2.6.1.5.8, request to no longer provide long-term care services to the member.
- 2.6.7.2.3 For CHOICES Group 2 and 3 members, patient liability shall be collected as follows:
 - 2.6.7.2.3.1 The CONTRACTOR shall delegate collection of patient liability for CHOICES Group 2 members who reside in a CBRA facility to the CBRA facility and shall pay the facility net of the applicable patient liability amount.
 - 2.6.7.2.3.2 The CONTRACTOR shall collect patient liability from CHOICES Group 2 and Group 3 members (as applicable) who receive CHOICES HCBS in his/her own home and from Group 2 members who receive Companion Care.
 - 2.6.7.2.3.2.1 The CONTRACTOR shall use calculated patient liability amounts to offset the cost of CHOICES Group 2 benefits (or CEA services provided as an alternative to covered CHOICES Group 2 benefits) reimbursed by the CONTRACTOR for that month.
 - 2.6.7.2.3.2.2 The CONTRACTOR shall not collect patient liability that exceeds the cost of CHOICES Group 2 benefits (or CEA services provided as an alternative to CHOICES Group 2 benefits) reimbursed by the CONTRACTOR for that month.
 - 2.6.7.2.3.2.3 The CONTRACTOR shall, upon notification in the outbound 834 enrollment file of retroactive adjustments in patient liability amounts based on Item D deductions, without requiring any action on the part of the member or provider, adjust the Group 2 or Group 3 member's patient liability for the following month(s) until reimbursement of any overpayment is accomplished, or shall refund any overpayments within thirty (30) days of a request from the member or when the member will not continue to have patient liability obligations going forward.
 - 2.6.7.2.3.3 If a Group 2 member fails to pay required patient liability, pursuant to Section 2.6.1.5.8.5, the CONTRACTOR may request to no longer provide long-term care services to the member.
 - 2.6.7.2.3.4 The CONTRACTOR shall not waive or otherwise fail to establish and maintain processes for collection of patient liability in accordance with this Agreement.

11. Section 2.7.2.1.2 shall be deleted and replaced as follows:

- 2.7.2.1.2 The CONTRACTOR shall provide behavioral health services in accordance with this Agreement, TennCare Rules and Regulations and TennCare policies, including Section 2.6 and Attachment I of this Agreement, and TennCare Medical Necessity Rule 1200-13-16.

12. Section 2.7.3 shall be deleted and replaced as follows:

2.7.3 Self-Direction of Health Care Tasks

The CONTRACTOR shall, in accordance with TennCare rules and regulations, permit CHOICES members the option to direct and supervise a consumer-directed worker who is providing eligible CHOICES HCBS in the performance of health care tasks.

13. Section 2.8.1.2 shall be amended by adding the phrase “and updated as described in current NCQA Standards” as follows:

2.8.1.2 Each DM program shall utilize evidence-based clinical practice guidelines (hereafter referred to as the guidelines) that have been formally adopted and updated as described in current NCQA Standards by the CONTRACTOR’s Quality Management/Quality Improvement (QM/QI) committee or other clinical committee as a clinical basis for development of program content and plan of care.

14. Section 2.8.1.6 shall be deleted and replaced as follows:

2.8.1.6 As part of its DM program descriptions, the CONTRACTOR shall also describe how the organization integrates member information and coordinates with and has timely access to MCO case management activities and other supporting entities, including but not limited to, Utilization Management (UM), CHOICES, Health Information Lines and Wellness programs, to assure programs are linked and enrollees receive appropriate and timely care.

15. Section 2.8.7.2 shall be amended by deleting the word “passive”.

2.8.7.2 The CONTRACTOR shall report the participation rates (as defined by NCQA) and the number of individuals participating in each level of each of the DM programs.

16. Sections 2.9.2.1.4 through 2.9.2.1.4.6.5 shall be deleted and replaced as follows:

2.9.2.1.4 For covered long-term care services for CHOICES members who are transferring from another MCO, the CONTRACTOR shall be responsible for continuing to provide covered long-term care services, including both CHOICES HCBS authorized by the transferring MCO and nursing facility services, without regard to whether such services are being provided by contract or non-contract providers.

2.9.2.1.4.1 For a member in CHOICES Group 2 or 3, the CONTRACTOR shall continue CHOICES HCBS authorized by the transferring MCO for a minimum of thirty (30) days after the member’s enrollment and thereafter shall not reduce these services unless a care coordinator has conducted a comprehensive needs assessment and developed a plan of care, and the CONTRACTOR has authorized and initiated CHOICES HCBS in accordance with the member’s new plan of care. If a member in CHOICES Group 2 or 3 is receiving short-term nursing facility care, the CONTRACTOR shall continue to provide nursing facility services to the member in accordance with the level of nursing facility services (Level I or Level II) and/or reimbursement approved by TENNCARE (see Section 2.14.1.12). For a member in Group 1, the CONTRACTOR shall provide nursing facility services to the member in accordance with the level of nursing facility

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services (Level I or Level II) and/or reimbursement approved by TENNCARE (see Section 2.14.1.12); however, the member may be transitioned to the community in accordance with Section 2.9.6.8 of this Agreement.

- 2.9.2.1.4.2 For a member in CHOICES Group 2 or 3, within thirty (30) days of notice of the member's enrollment with the CONTRACTOR, a care coordinator shall conduct a face-to-face visit (see Section 2.9.6.2.5), including a comprehensive needs assessment (see Section 2.9.6.5), and develop a plan of care (see Section 2.9.6.6), and the CONTRACTOR shall authorize and initiate CHOICES HCBS in accordance with the new plan of care (see Section 2.9.6.2.5). If a member in Group 2 or 3 is receiving short-term nursing facility care on the date of enrollment with the CONTRACTOR, a care coordinator shall complete a face-to-face visit prior to the expiration date of the level of nursing facility services approved by TENNCARE, but no later than thirty (30) days after enrollment to determine appropriate needs assessment and care planning activities (see Section 2.9.6.2.5 for members who will be discharged from the nursing facility and remain in Group 2 or 3 and Section 2.9.6.2.4 for members who will remain in the nursing facility and be enrolled in Group 1). If the expiration date for the level of nursing facility services approved by TENNCARE occurs prior to thirty (30) days after enrollment, and the CONTRACTOR is unable to conduct the face-to-face visit prior to the expiration date, the CONTRACTOR shall be responsible for facilitating discharge to the community or enrollment in Group 1, whichever is appropriate prior to the member's exhaustion of the 90-day short-term NF benefit.
- 2.9.2.1.4.3 If at any time before conducting a comprehensive needs assessment for a member in CHOICES Group 2 or 3 the CONTRACTOR becomes aware of an increase in the member's needs, a care coordinator shall immediately conduct a comprehensive needs assessment and update the member's plan of care, and the CONTRACTOR shall initiate the change in services within ten (10) days of becoming aware of the increase in the member's needs.
- 2.9.2.1.4.4 For a member in CHOICES Group 1, a care coordinator shall conduct a face-to-face in-facility visit within thirty (30) days of the member's enrollment with the CONTRACTOR and conduct a needs assessment as determined necessary by the CONTRACTOR (see Section 2.9.6.5).
- 2.9.2.1.4.5 The CONTRACTOR shall facilitate a seamless transition to new services and/or providers, as applicable, in the plan of care developed by the CONTRACTOR without any disruption in services.
- 2.9.2.1.4.6 The CONTRACTOR shall not:
 - 2.9.2.1.4.6.1 Transition nursing facility residents or residents of community-based residential alternatives to another facility unless (1) the member or his/her representative specifically requests to transition, which shall be documented in the member's file, (2) the member or his/her representative provides written consent to transition based on quality or other concerns raised by the CONTRACTOR, which shall not include the nursing facility's rate of reimbursement; or (3) the facility where the member is residing is not a contract provider; if the community-based residential facility where the member is currently residing is not a contract provider, the CONTRACTOR shall provide continuation of services in such facility for at least thirty (30) days, which shall be extended as necessary to ensure continuity of care pending the facility's contracting with the CONTRACTOR

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or the member's transition to a contract facility; if the member is transitioned to a contract facility, the CONTRACTOR shall facilitate a seamless transition to the new facility; if the nursing facility where the member is currently residing is a non-contract provider, the CONTRACTOR shall (a) authorize continuation of the services pending enrollment of the facility as a contract provider (except a facility excluded for a 2-year period when the facility has withdrawn from Medicaid participation); (b) authorize continuation of the services pending facilitation of the member's transition to a contract facility, subject to the member's agreement with such transition; or (c) may continue to reimburse services from the non-contract nursing facility in accordance with TennCare rules and regulations;

- 2.9.2.1.4.6.2 Transition Group 1 members to CHOICES HCBS unless the member chooses to receive CHOICES HCBS as an alternative to nursing facility care and is enrolled in CHOICES Group 2 (see Section 2.9.6.8 for requirements regarding nursing facility to community transition);
 - 2.9.2.1.4.6.3 Admit a member in CHOICES Group 2 to a nursing facility unless (1) the member requires a short-term nursing facility care stay; (2) the member chooses to transition to a nursing facility and enroll in Group 1; or (3) the CONTRACTOR determines that it cannot safely and effectively meet the needs of the member and within the member's cost neutrality cap, and the member agrees to transition to a nursing facility and enroll in Group 1;
 - 2.9.2.1.4.6.4 Admit a member enrolled in CHOICES Group 3 to a nursing facility unless: (1) the member meets nursing facility level of care and is expected to require nursing facility services for ninety (90) days or less; or (2) the member meets nursing facility level of care, is expected to require nursing facility services for more than ninety (90) days and chooses to transition to a nursing facility and enroll in Group 1; or
 - 2.9.2.1.4.6.5 Transition members in Group 2 or 3 to another HCBS provider for continuing services unless the current HCBS provider is not a contract provider; if the current HCBS provider is not a contract provider, the CONTRACTOR shall provide continuation of HCBS from that provider for at least thirty (30) days, which shall be extended as necessary to ensure continuity of care pending the provider's contracting with the CONTRACTOR or the member's transition to a contract provider; if the member is transitioned to a contract provider, the CONTRACTOR shall facilitate a seamless transition to the new provider.
- 17. Sections 2.9.2.1.5 through 2.9.2.1.5.6.4 shall be deleted in their entirety including any references thereto.**
- 18. Section 2.9.2.5 shall be deleted and replaced as follows:**
- 2.9.2.5 If the CONTRACTOR becomes aware that a CHOICES member will be transferring to another MCO, the CONTRACTOR (including, but not limited to the member's care coordinator or care coordination team) shall, in accordance with protocols established by TENNCARE, work with the other MCO in facilitating a seamless transition for that member.

19. Section 2.9.3.3, 2.9.3.4 and 2.9.3.6 shall be deleted and replaced as follows:

- 2.9.3.3 For members in Group 2 the CONTRACTOR shall continue HCBS in the member's approved HCBS E/D waiver plan of care except case management for a minimum of thirty (30) days after the member's enrollment and thereafter shall not reduce HCBS unless the member's care coordinator has conducted a comprehensive needs assessment and developed a plan of care and the CONTRACTOR has authorized and initiated HCBS in accordance with the member's new plan of care. If a member in CHOICES Group 2 is receiving short-term nursing facility care, the CONTRACTOR shall continue to provide nursing facility services to the member in accordance with the level of nursing facility services (Level I or Level II) and/or reimbursement approved by TENNCARE (see Section 2.14.1.12).
- 2.9.3.4 For a member in CHOICES Group 2, within ninety (90) days of CHOICES implementation, the member's care coordinator shall conduct a face-to-face visit (see Section 2.9.6.2.5), including a comprehensive needs assessment (see Section 2.9.6.5), and develop a plan of care (see Section 2.9.6.6), and the CONTRACTOR shall authorize and initiate CHOICES HCBS in accordance with the new plan of care. If a member in Group 2 is receiving short-term nursing facility care on the date of enrollment with the CONTRACTOR the member's care coordinator shall complete a face-to-face visit prior to the expiration date of the level of nursing services approved by TENNCARE, but no more than ninety (90) days after CHOICES implementation, to determine appropriate needs assessment and care planning activities (see Section 2.9.6.2.5 for members who will be discharged from the nursing facility and remain in Group 2 or 3 and Section 2.9.6.2.4 for members who will remain in the nursing facility and be enrolled in Group 1). If the expiration date for the level of nursing facility services approved by TENNCARE occurs prior to ninety (90) days after CHOICES implementation, and the CONTRACTOR is unable to conduct the face-to-face visit prior to the expiration date, the CONTRACTOR shall be responsible for facilitating discharge to the community or enrollment in Group 1, whichever is appropriate.
- 2.9.3.6 The CONTRACTOR shall provide nursing facility services to a member in Group 1 in accordance with the level of nursing facility services (Level I or Level II) and/or reimbursement approved by TENNCARE (see Section 2.14.1.12); however, the member may be transitioned to the community in accordance with Section 2.9.6.8 of this Agreement.

20. Section 2.9.3.9.2 and 2.9.3.9.4 shall be deleted and replaced as follows:

- 2.9.3.9.2 Transition Group 1 members to CHOICES HCBS unless the member chooses to receive CHOICES HCBS as an alternative to nursing facility care and is enrolled in CHOICES Group 2 (see Section 2.9.6.8 for requirements regarding nursing facility to community transition);
- 2.9.3.9.4 Transition members in Group 2 or 3 to another HCBS provider for continuing services unless the current HCBS provider is not a contract provider; if the current HCBS provider is not a contract provider, the CONTRACTOR shall provide continuation of CHOICES HCBS from that provider for at least thirty (30) days, which shall be extended as necessary to ensure continuity of care pending the provider's contracting with the CONTRACTOR or the member's transition to a contract provider; if the member is transitioned to a contract provider, the CONTRACTOR shall facilitate a seamless transition to the new provider.

21. Section 2.9.6.1 shall be amended by adding a new Section 2.9.6.1.6 and renumbering the remaining Sections accordingly, including any references thereto.

2.9.6.1.6 The CONTRACTOR shall compute Care Coordination CHOICES-related timelines as follows;

2.9.6.1.6.1 The day of the initiating event (e.g., receipt of a referral or receipt of the outbound 834 enrollment file is not to be included in the computation;

2.9.6.1.6.2 The Calendar Day immediately following the initiating event is day one (1) of timelines utilizing calendar days. Each subsequent calendar day is included in the computation; and

2.9.6.1.6.3 The Business Day (see Section 1) immediately following the initiating event is day one (1) of timelines utilizing business days. Each subsequent business day is included in the computation.

22. Sections 2.9.6.2.3 through 2.9.6.2.3.8 shall be deleted and replaced as follows:

2.9.6.2.3 *Functions of the Single Point of Entry (SPOE)*

2.9.6.2.3.1 For persons wishing to apply for CHOICES, TENNCARE or its designee may employ a screening process, using the tools and protocols specified by TENNCARE, to assist with intake for persons new to both TennCare and CHOICES. Such screening process shall assess: (1) whether the applicant appears to meet categorical and financial eligibility criteria for CHOICES; (2) whether the applicant appears to meet nursing facility level of care; and (3) for applicants seeking access to CHOICES HCBS through enrollment in CHOICES Group 2, whether it appears that the applicant's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care.

2.9.6.2.3.2 For persons identified by TENNCARE or its designee as meeting the screening criteria, or for whom TENNCARE or its designee opts not to use a screening process, TENNCARE or its designee will conduct a face-to-face intake visit with the applicant. As part of this intake visit TENNCARE or its designee will, using the tools and protocols specified by TENNCARE, conduct a level of care and needs assessment; assess the member's existing natural support system, including but not limited to informal supports provided by family and other caregivers, services that may be available at no cost to the member through other entities, and services that are reimbursable through other public or private funding sources, such as Medicare or long-term care insurance; and identify the long-term care services and home health and/or private duty nursing services that may be needed by the applicant upon enrollment into CHOICES that would build upon and not supplant a member's existing natural support system.

2.9.6.2.3.3 TENNCARE or its designee shall conduct the intake visit, including the level of care and needs assessment, in the applicant's place of residence, except under extenuating circumstances (such as the member's hospitalization), which shall be documented in writing.

2.9.6.2.3.4 As part of the intake visit, TENNCARE or its designee shall: (1) provide general CHOICES education and information, as specified by TENNCARE, and assist in

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answering any questions the applicant may have; (2) provide information about estate recovery; (3) provide choice counseling and facilitate the selection of an MCO by the applicant or his/her representative; (4) provide information regarding freedom of choice of nursing facility versus CHOICES HCBS, both verbally and in writing, and obtain a Freedom of Choice form signed and dated by the applicant or his/her representative; (5) provide detailed information and obtain signed acknowledgement of understanding regarding a CHOICES member's responsibility with respect to payment of patient liability amounts, including, as applicable, the potential consequences for non-payment of patient liability which may include loss of the member's current nursing facility or CBRA provider or MCO, disenrollment from CHOICES, and to the extent the member's eligibility is dependent on receipt of long-term care services, possible loss of eligibility for TennCare; and (6) for applicants who want to receive NF services, provide information regarding the completion of all PASRR requirements prior to nursing facility admission and conduct the level I PASRR screening; (7) for applicants who are seeking CHOICES HCBS: (a) conduct a risk assessment using a tool and protocol specified by TENNCARE and develop, as applicable, a risk agreement that shall be signed by the applicant or his/her representative and which shall include identified risks to the applicant, the consequences of such risks, strategies to mitigate the identified risks, and the applicant's decision regarding his/her acceptance of risk; (b) make a determination regarding whether the applicant's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care, including explanation to the applicant regarding the individual cost neutrality cap, including that a change in a member's needs or circumstances that would result in the cost neutrality cap being exceeded or that would result in the MCO's inability to safely and effectively meet a member's needs in the community and within the cost neutrality cap may result in the member's disenrollment from CHOICES Group 2, in which case, the care coordinator will assist with transition to a more appropriate care delivery setting; and (c) provide information regarding consumer direction and obtain signed documentation of the applicant's interest in participating in consumer direction; and (8) provide information regarding next steps in the process including the need for approval by TENNCARE to enroll in CHOICES and the functions of the CONTRACTOR, including that the CONTRACTOR will develop and approve a plan of care.

- 2.9.6.2.3.5 The listing of CHOICES HCBS and home health and/or private duty nursing services the member may need shall be used by TENNCARE or its designee to determine whether services can be provided within the member's cost neutrality cap and may be further refined based on the CONTRACTOR's comprehensive needs assessment and plan of care development processes.
- 2.9.6.2.3.6 The State will be responsible for determining TennCare categorical and financial eligibility and level of care and enrolling eligible TennCare members into CHOICES.
- 2.9.6.2.3.7 TENNCARE will notify the CONTRACTOR via the outbound 834 enrollment file when a person has been enrolled in CHOICES, the member's CHOICES Group, and any applicable patient liability amounts (See Section 2.6.7). For members in CHOICES Group 2, TENNCARE will notify the CONTRACTOR of the member's cost neutrality cap (see definition in Section 1 and Section 2.6.1.5.2.3), which shall be the average cost of Level 1 nursing facility care unless a higher cost neutrality cap is established by TENNCARE based on information submitted by the AAAD or MCO (as applicable) in the level of care.

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2.9.6.2.3.8 TENNCARE or its designee will make available to the CONTRACTOR the documentation from the intake visit, including but not limited to the member's level of care and needs assessment, the assessment of the member's existing natural support system, the member's risk assessment and signed risk agreement (for members in CHOICES Group 2), and the services identified by TENNCARE or its designee that the member may need upon CHOICES enrollment.

23. Sections 2.9.6.2.4 through 2.9.6.2.4.8 shall be deleted and replaced as follows:

2.9.6.2.4 *Functions of the CONTRACTOR for Members in CHOICES Group 1*

2.9.6.2.4.1 For members enrolled in CHOICES Group 1, who are, upon CHOICES enrollment, receiving nursing facility services, the CONTRACTOR shall reimburse such services in accordance with the level of nursing facility services (Level I or Level II) and/or reimbursement approved by TENNCARE (see Section 2.14.1.12), except that the CONTRACTOR may reimburse a lesser level of service when such lesser level of service is billed by the facility. Reimbursement for such services shall be from the current provider as of the effective date of CHOICES enrollment. The CONTRACTOR shall not move members enrolled in CHOICES Group 1 who are, upon CHOICES enrollment, receiving nursing facility services, to another facility unless: (1) the member or his/her representative specifically requests to move, which shall be documented in the member's file; (2) the member or his/her representative provides written consent to move based on quality or other concerns raised by the CONTRACTOR, which shall not include the nursing facility's rate of reimbursement; or (3) the facility where the member is residing is not a contract provider. If the nursing facility is a non-contract provider, the CONTRACTOR shall (a) provide continuation of the services pending enrollment of the facility as a contract provider (except a facility excluded for a 2-year period when the facility has withdrawn from Medicaid participation); (b) provide continuation of the services pending facilitation of the member's transition to a contract facility, subject to the member's agreement with such transition; or (c) may continue to reimburse services from the non-contract nursing facility in accordance with TennCare rules and regulations.

2.9.6.2.4.2 The CONTRACTOR shall, within thirty (30) calendar days of notice of the member's enrollment in CHOICES, conduct a face-to-face visit with the member and perform any additional needs assessment deemed necessary by the CONTRACTOR (see Section 2.9.6.5.1). The care coordinator shall review the plan of care developed by the nursing facility and may supplement the plan of care as necessary and appropriate (see Section 2.9.6.6.1).

2.9.6.2.4.3 The CONTRACTOR shall not transition members in Group 1 to CHOICES HCBS unless the member chooses to receive CHOICES HCBS as an alternative to nursing facility and is enrolled in Group 2.

2.9.6.2.4.4 For purposes of the CHOICES program, the CONTRACTOR may decide whether it will issue service authorizations for nursing facility services, or whether it will instead process claims for such services in accordance with the level of care and/or reimbursement (including the duration of such level of care and/or reimbursement) approved by TENNCARE (see Section 2.14.1.12), except that the CONTRACTOR may reimburse a lesser level of service when such lesser level of service is billed by the facility. .

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- 2.9.6.2.4.5 For CHOICES members approved by TENNCARE for Level II (or skilled) nursing facility services, the CONTRACTOR shall be responsible for monitoring the member's continued need for Medicaid reimbursed skilled and/or rehabilitation services, promptly notifying TENNCARE when Level II nursing facility services are no longer medically necessary, and for the submission of information needed by TENNCARE to reevaluate the member's level of care for nursing facility services (see also Section 2.14.1.12.2).
- 24. Sections 2.9.6.2.5.2 and 2.9.6.2.5.3 shall be amended by adding the word "CHOICES" in front of the word "HCBS".**
- 25. Sections 2.9.6.2.5.8 through 2.9.6.2.5.13 shall be deleted and replaced as follows:**
- 2.9.6.2.5.8 As part of the face-to-face visit for members in CHOICES Group 2, the care coordinator shall review, and revise as necessary, the member's risk assessment and risk agreement and have the member or his/her representative sign and date any revised risk agreement.
- 2.9.6.2.5.9 As part of the face-to-face visit, for members determined to need eligible CHOICES HCBS, the care coordinator shall verify the member's interest in participating in consumer direction and obtain written confirmation of the member's decision. The care coordinator shall also provide member education regarding choice of contract providers for CHOICES HCBS, subject to the provider's availability and willingness to timely deliver services, and obtain signed confirmation of the member's choice of contract providers.
- 2.9.6.2.5.10 For purposes of CHOICES HCBS, service authorizations shall include the amount, frequency, and duration of each service to be provided and the schedule at which such care is needed, as applicable; the requested start date; and other relevant information as prescribed by TENNCARE. The CONTRACTOR shall be responsible for confirming the provider's capacity and commitment to initiate services as authorized on or before the requested start date, and if the provider is unable to initiate services as authorized on or before the requested start date, for arranging an alternative provider who is able to initiate services as authorized on or before the requested start date.
- 2.9.6.2.5.11 The member's care coordinator/care coordination team shall provide at least verbal notification to the member prior to initiation of CHOICES HCBS identified in the plan of care regarding any change in providers selected by the member for each CHOICES HCBS, including the reason such change has been made.
- 2.9.6.2.5.12 If the CONTRACTOR is unable to initiate any CHOICES HCBS in accordance with the timeframes specified herein, the CONTRACTOR shall issue written notice to the member, documenting the service(s) that will be delayed, the reasons for the delay, and the date the service(s) will start, and shall make good faith efforts to ensure that services are provided as soon as practical.
- 2.9.6.2.5.13 TENNCARE may establish, pursuant to policies and protocols for management of waiting lists, alternative timeframes for completion of specified intake functions and activities when there is a waiting list.

26. Section 2.9.6.3.1.5 through 2.9.6.3.1.5.5 shall be deleted and replaced as follows:

- 2.9.6.3.1.5 Periodic review (at least quarterly) of:
 - 2.9.6.3.1.5.1 Claims or encounter data;
 - 2.9.6.3.1.5.2 Hospital admission or discharge data;
 - 2.9.6.3.1.5.3 Pharmacy data; and
 - 2.9.6.3.1.5.4 Data collected through the DM and/or UM processes.
 - 2.9.6.3.1.5.5 The CONTRACTOR may define in its policies and procedures other steps that will be taken to better assess if the members identified through means other than referral or notice of hospital admission will likely qualify for CHOICES, and may target its screening and intake efforts to a more targeted list of persons that are most likely to need and to qualify for CHOICES services.
- 2.9.6.3.1.5.6 TENNCARE may establish, pursuant to policies and protocols for management of waiting lists, alternative timeframes for completion this task when there is a waiting list.

27. Section 2.9.6.3.2 shall be deleted and replaced as follows:

- 2.9.6.3.2 As part of its identification process for members who may be eligible for CHOICES, the CONTRACTOR may initiate a telephone screening process, using the tool and protocols specified by TENNCARE. Such screening process shall: (1) verify the member’s current eligibility category based on information provided by TENNCARE in the outbound 834 enrollment file; for persons seeking access to CHOICES HCBS through enrollment in CHOICES Groups 2 or 3, identify whether the member meets categorical eligibility requirements for enrollment in such group based on his/her current eligibility category, and if not, for persons seeking to enroll in CHOICES Group 2, whether the member appears to meet categorical and financial eligibility criteria for the Institutional (i.e., CHOICES 217-Like HCBS) category; (2) determine whether the member appears to meet level of care eligibility for CHOICES; and (3) for members seeking access to CHOICES HCBS through enrollment in CHOICES Group 2, determine whether it appears that the member’s needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care. Such telephone screening shall be conducted at the time of the initial call by the CONTRACTOR unless the member requests that the screening be conducted at another time, which shall be documented in writing in the CHOICES intake record.

28. Section 2.9.6.3.3.1 shall be deleted and replaced as follows:

- 2.9.6.3.3.1 Documentation of at least three (3) attempts occurring over a period of no less than three (3) days to contact the member by phone (which shall include at least one (1) attempt to contact the member at the number most recently reported by the member and at least one (1) attempt to contact the member at the number provided in the referral, if different, and which shall occur at different times of the day and evening, including after business hours), followed by a letter sent to the member’s most recently reported address that provides information about CHOICES and how to obtain a screening for CHOICES, shall constitute sufficient effort by the CONTRACTOR to assist a member who has been

referred for CHOICES, regardless of referral source. TENNCARE will review the CONTRACTOR's referral data, including the number of referred members the CONTRACTOR is unable to reach, and may institute additional requirements as necessary to ensure reasonable efforts to reach the member and complete the referral and intake process.

29. Section 2.9.6.3.7 shall be deleted and replaced as follows:

2.9.6.3.7 If the member does not meet the telephone screening criteria, the CONTRACTOR shall notify the member verbally and in writing in the format prescribed by TENNCARE: (1) that he/she does not appear to meet the criteria for enrollment in CHOICES; (2) that he/she has the right to continue with the CHOICES intake process and, if determined not eligible, to receive notice of such denial, including the member's due process right to appeal; and (3) how, if the member wishes to proceed with the CHOICES intake process, the member can submit a written request to proceed with the CHOICES intake process to the CONTRACTOR. In the event that a member does submit such written request, the CONTRACTOR shall process the request as a new referral and shall conduct a face-to-face intake visit, including level of care assessment and needs assessment, within ten (10) business days of receipt of the member's written request, unless a later date is requested by the member, which shall be documented in writing in the CHOICES intake record.

30. Section 2.9.6.3.8.2 shall be amended by adding the word "CHOICES" in front of the word "HCBS".

31. Sections 2.9.6.3.9 through 2.9.6.3.18 shall be deleted and replaced as follows:

2.9.6.3.9 As part of the face-to-face intake visit, the care coordinator shall: (1) provide general CHOICES education and information, as specified by TENNCARE, to the member and assist in answering questions the member may have; (2) provide information about estate recovery; (3) provide assistance, as necessary, in facilitating gathering of categorical/financial documentation needed by DHS; (4) provide information regarding freedom of choice of nursing facility versus CHOICES HCBS, both verbally and in writing, and obtain a Freedom of Choice form signed and dated by the member or his/her representative; (5) provide detailed information and signed acknowledgement of understanding regarding a CHOICES member's responsibility with respect to payment of patient liability amounts, including, as applicable, the potential consequences for non-payment of patient liability which may include loss of the member's current nursing facility or CBRA provider or MCO, disenrollment from CHOICES, and to the extent the member's eligibility is dependent on receipt of long-term care services, possible loss of eligibility for TennCare; and (6) for members who want to receive nursing facility services, provide information regarding the completion of all PASRR requirements prior to nursing facility admission and conduct the level I PASRR screening; (7) for members who are seeking CHOICES HCBS, the care coordinator, shall: (a) conduct a risk assessment using a tool and protocol specified by TENNCARE and shall develop, as applicable, a risk agreement that shall be signed and dated by the member or his/her representative and which shall include identified risks to the member, the consequences of such risks, strategies to mitigate the identified risks, and the member's decision regarding his/her acceptance of risk; (b) make a determination regarding whether the person's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care, and provide explanation to the member regarding the individual cost neutrality cap, including that a change in needs or circumstances that would result in the cost neutrality

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cap being exceeded or that would result in the CONTRACTOR's inability to safely and effectively meet the member's needs in the community and within the cost neutrality cap may result in the member's disenrollment from CHOICES Group 2, in which case, the member's care coordinator will assist with transition to a more appropriate care delivery setting; and (c) provide information regarding consumer direction and obtain written confirmation of the member's decision regarding participation in consumer direction; and (8) for all members, provide information regarding choice of contract providers, subject to the provider's availability and willingness to timely deliver services, and obtain signed documentation of the member's choice of contract providers.

- 2.9.6.3.10 If the member does not meet appear to meet CHOICES enrollment criteria, the care coordinator may advise the member verbally: (1) that he/she does not appear to meet the criteria for enrollment in CHOICES; but shall also advise the member (2) that he/she has the right to continue with the CHOICES intake process and, if determined not eligible, to receive notice of such denial, including the member's due process right to a fair hearing.
- 2.9.6.3.10.1 The decision to discontinue the CHOICES intake process must be made by the member or the member's representative and the CONTRACTOR shall not encourage the member or member's representative to discontinue the process;
- 2.9.6.3.10.2 Upon the member's decision to continue the CHOICES intake, the care coordinator shall continue the intake process and complete all required activities, including submission of the level of care to TENNCARE; or
- 2.9.6.3.10.3 Upon the member's decision to discontinue the CHOICES intake process, the care coordinator shall, in the manner prescribed by TENNCARE, document the member's decision to terminate the CHOICES intake process, including the member's or representative's signature and date. The CONTRACTOR shall maintain this documentation in the member's record and provide a copy to the member/representative.
- 2.9.6.3.10.4 The CONTRACTOR shall provide the member with information about how to initiate a new CHOICES screening and intake process in the future.
- 2.9.6.3.11 If, during the face-to-face intake visit the member or the member's representative elects to terminate the intake process for any other reason (e.g., estate recovery, patient liability, or does not need the services available through CHOICES), the care coordinator shall, in the manner prescribed by TENNCARE, document the member's decision to terminate the CHOICES intake process, including the member's or representative's signature and date. The CONTRACTOR shall maintain this documentation in the member's record and provide a copy to the member/representative.
- 2.9.6.3.11.1 The decision to discontinue the CHOICES intake process must be made by the member or the member's representative and the CONTRACTOR shall not encourage the member or member's representative to discontinue the process;
- 2.9.6.3.11.2 The CONTRACTOR shall provide the member with information about how to initiate a new CHOICES screening and intake process in the future.
- 2.9.6.3.12 For CHOICES referrals by or on behalf of a potential CHOICES member, regardless of referral source, the care coordinator shall conduct the face-to-face intake visit and shall develop a plan of care, as appropriate (see Section 2.9.6.6), within ten (10) business days of

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receipt of such referral, unless a later date is requested by the member, which shall be documented in writing in the CHOICES intake record.

- 2.9.6.3.13 For members identified by the CONTRACTOR as potentially eligible for CHOICES by means other than referral, the care coordinator shall conduct the face-to-face intake visit and shall develop a plan of care, as appropriate (see Section 2.9.6.6), within thirty (30) days of identification of the member as potentially eligible for CHOICES. For persons identified through notification of hospital admission, the CONTRACTOR shall coordinate with the hospital discharge planner to determine whether long-term care services may be needed upon discharge, and if so, complete all applicable screening and/or intake processes immediately to facilitate timely transition to the most integrated and cost effective long-term care delivery setting appropriate for the member's needs.
- 2.9.6.3.14 Once completed, the CONTRACTOR shall submit the level of care and, for members requesting CHOICES HCBS, documentation, as specified by TENNCARE, to verify that the member's needs can be safely and effectively met in the community and within the cost neutrality cap to TENNCARE as soon as possible but no later than five (5) business days of the face-to-face visit. The CONTRACTOR shall make every effort to obtain supporting documentation required for the level of care in a timely manner and shall document in writing the cause of any delay in the submission of the required documentation to TENNCARE, including the CONTRACTOR's actions to mitigate such delay. The CONTRACTOR shall be responsible for ensuring that the level of care is accurate and complete, satisfies all technical requirements specified by TENNCARE, and accurately reflects the member's current medical and functional status based on information gathered, at a minimum, from the member, his or her representative, the Care Coordinator's direct observations, and the history and physical or other medical records which shall be submitted with the application. The CONTRACTOR shall note in the level of care any discrepancies between these sources of information, and shall provide explanation regarding how the CONTRACTOR addressed such discrepancies in the level of care.
- 2.9.6.3.15 If the member is seeking access to CHOICES HCBS through enrollment in CHOICES Group 2 and the enrollment target for CHOICES Group 2 has been reached, the CONTRACTOR shall notify TENNCARE, at the time of submission of the level of care and needs assessment and plan of care, as appropriate, whether the person shall be placed on a waiting list for CHOICES Group 2. If the CONTRACTOR wishes to enroll the person in CHOICES Group 2 as a cost effective alternative (CEA) to nursing facility care that would otherwise be provided, the CONTRACTOR shall submit to TENNCARE the following:
 - 2.9.6.3.15.1 A written summary of the CONTRACTOR's CEA determination, including an explanation of the member's circumstances which warrant the immediate provision of nursing facility services unless CHOICES HCBS are immediately available.
 - 2.9.6.3.15.2 TENNCARE may request additional information as needed to confirm the CONTRACTOR's CEA determination and/or provider capacity to meet the member's needs, and shall, only upon receipt of satisfactory documentation, enroll the member in CHOICES.
- 2.9.6.3.16 The CONTRACTOR shall be responsible for (1) advising members who appear to meet the nursing facility level of care that are seeking access to CHOICES HCBS through enrollment in CHOICES Group 2 when an enrollment target has been (or will soon be) reached; (2) advising such persons that they may choose to receive nursing facility services if CHOICES

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HCBS are not immediately available; (3) determining whether the person wants nursing facility services if CHOICES HCBS are not immediately available; and (4) at the CONTRACTOR's sole discretion, making a determination regarding whether enrollment in Group 2 constitutes a CEA because the immediate provision of nursing facility services will otherwise be required and submitting appropriate documentation to TENNCARE if there is a waiting list for CHOICES Group 2 but the CONTRACTOR chooses to enroll a member in Group 2 as a CEA (see Section 2.9.6.3.13.1).

- 2.9.6.3.17 The State will be responsible for determining TennCare categorical and financial eligibility and level of care and enrolling eligible TennCare members into CHOICES.
- 2.9.6.3.18 TENNCARE will notify the CONTRACTOR via the outbound 834 enrollment file when a person has been enrolled in CHOICES and, if the member is enrolled in CHOICES, the member's CHOICES Group and applicable patient liability amounts (see Section 2.6.7). For members in CHOICES Group 2, TENNCARE will notify the CONTRACTOR of the member's cost neutrality cap (see definition in Section 1 and see Section 2.6.1.5.2.3), which shall be the average cost of Level 1 nursing facility care unless a higher cost neutrality cap is established by TENNCARE based on information submitted by the AAAD or MCO (as applicable) in the level of care.
- 2.9.6.3.19 For all newly enrolled CHOICES Group 1 members, the CONTRACTOR shall reimburse NF services in accordance with the level of nursing facility services or reimbursement approved by TENNCARE, and as of the effective date of CHOICES enrollment, except that the CONTRACTOR may reimburse a lesser level of service which such lesser level of service is billed by the facility.
- 2.9.6.3.20 For the CONTRACTOR's current members enrolled into CHOICES Group 2, the member's Care Coordinator shall within ten (10) business days of notice of the member's enrollment in CHOICES Group 2, authorize and initiate CHOICES HCBS.
 - 2.9.6.3.20.1 For purposes of the CHOICES program, service authorizations for CHOICES HCBS shall include the amount, frequency, and duration of each service to be provided, and the schedule at which such care is needed, as applicable; and other relevant information as prescribed by TENNCARE. The CONTRACTOR may decide whether it will issue service authorizations for nursing facility services, or whether it will instead process claims for such services in accordance with the level of care and/or reimbursement (including the duration of such level of care and/or reimbursement) approved by TENNCARE (see Section 2.14.1.12), except that the CONTRACTOR may reimburse a lesser level of service when such lesser level of service is billed by the facility.
 - 2.9.6.3.20.2 The CONTRACTOR shall provide at least verbal notice to the member prior to initiation of CHOICES HCBS identified in the plan of care regarding any change in providers selected by the member for each CHOICES HCBS; including the reason such change has been made. If the CONTRACTOR is unable to place a member in the nursing facility or community-based residential alternative setting requested by the member, the care coordinator shall meet with the member and his/her representative to discuss the reasons why the member cannot be placed with the requested facility and the available options and identify an alternative facility.
 - 2.9.6.3.20.3 If the CONTRACTOR is unable to initiate any long-term care service within the timeframes specified in this Agreement, the CONTRACTOR shall issue written notice to

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the member, documenting the service(s) that will be delayed, the reasons for the delay and the date the service(s) will start, and shall make good faith efforts to ensure that services are provided as soon as practical.

- 2.9.6.3.20.4 For members enrolled in CHOICES Groups 1 or 2 who are, upon CHOICES enrollment, receiving nursing facility or community-based residential alternative services from a contract provider, the CONTRACTOR shall authorize such services from the current provider as of the effective date of CHOICES enrollment. The CONTRACTOR shall not move members enrolled in CHOICES Groups 1 or 2 who are, upon CHOICES enrollment, receiving services in a nursing facility or community-based residential alternative setting to another facility unless: (1) the member or his/her representative specifically requests to move, which shall be documented in the member's file; (2) the member or his/her representative provides written consent to move based on quality or other concerns raised by the CONTRACTOR, which shall not include the nursing facility's rate of reimbursement; or (3) the facility where the member is residing is not a contract provider; if the community-based residential facility where the member is currently residing is not a contract provider, the CONTRACTOR shall provide continuation of services in such facility for at least thirty (30) days, which shall be extended as necessary to ensure continuity of care pending the facility's contracting with the CONTRACTOR or the member's transition to a contract facility; if the member is transitioned to a contract facility, the CONTRACTOR shall facilitate a seamless transition to the new facility; if the nursing facility where the member is currently residing is a non-contract provider, the CONTRACTOR shall (a) authorize continuation of the services pending enrollment of the facility as a contract provider (except a facility excluded for a 2-year period when the facility has withdrawn from Medicaid participation); (b) authorize continuation of the services pending facilitation of the member's transition to a contract facility, subject to the member's agreement with such transition; or (c) may continue to reimburse services from the non-contract nursing facility in accordance with TennCare rules and regulations.
- 2.9.6.3.20.5 For members receiving nursing facility services, the care coordinator shall participate as appropriate in the nursing facility's care planning process (see Section 2.9.6.5.1) and may supplement the facility's plan of care as necessary (see Section 2.9.6.6.1).
- 2.9.6.3.20.6 The CONTRACTOR shall not divert or transition members in CHOICES Group 1 to CHOICES HCBS unless the member chooses to receive CHOICES HCBS as an alternative to nursing facility and is enrolled in Group 2.
- 2.9.6.3.20.7 The CONTRACTOR shall not admit a member enrolled in CHOICES Group 2 to a nursing facility unless: (1) the member requires a short-term nursing facility care stay; (2) the member chooses to transition to a nursing facility and enroll in Group 1; or (3) the CONTRACTOR determines that it cannot safely and effectively meet the needs of the member and at a cost that is less than the member's cost neutrality cap and the member agrees to transition to a nursing facility and enroll in Group 1.
- 2.9.6.3.20.8 The CONTRACTOR shall not admit a member enrolled in CHOICES Group 3 to a nursing facility unless: (1) the member meets nursing facility level of care and is expected to require nursing facility services for ninety (90) days or less; or (2) the member meets nursing facility level of care, is expected to require nursing facility services for more than ninety (90) days and chooses to transition to a nursing facility and enroll in Group 1.

2.9.6.3.21 TENNCARE may establish, pursuant to policies and protocols for management of waiting lists, alternative timeframes for completion of specified intake functions and activities for persons when there is a waiting list.

32. Section 2.9.6.4.4 shall be deleted and replaced as follows:

2.9.6.4.4 The CONTRACTOR may utilize a care coordination team approach to performing care coordination activities prescribed in Section 2.9.6. For each CHOICES member, the CONTRACTOR's care coordination team shall consist of the member's care coordinator and specific other persons with relevant expertise and experience appropriate to address the needs of CHOICES members. Care coordination teams shall be discrete entities within the CONTRACTOR's organizational structure dedicated to fulfilling CHOICES care coordination functions. The CONTRACTOR shall establish policies and procedures that specify, at a minimum: the composition of care coordination teams; the tasks that shall be performed directly by the care coordinator as specified in this Agreement, including needs assessment, development of the plan of care, and all minimum care coordination contacts; the tasks that may be performed by the care coordinator or the care coordination team; measures taken to ensure that the care coordinator remains the member's primary point of contact for the CHOICES program and related issues; escalation procedures to elevate issues to the care coordinator in a timely manner; and measures taken to ensure that if a member needs to reach his/her care coordinator specifically, calls that require immediate attention by a care coordinator are handled by a care coordinator and calls that do not require immediate attention are returned by the member's care coordinator the next business day. The CONTRACTOR may elect to utilize specialized intake coordinators or intake teams for initial needs assessment and care planning activities. All intake activities identified as responsibilities of the care coordinator shall be completed by an individual who meets all of the requirements to be a care coordinator. Should the CONTRACTOR elect to utilize specialized intake coordinators or intake teams, the CONTRACTOR shall develop policies and procedures which specify how the contractor will coordinate a seamless transfer of information from the intake coordinator or team to the member's care coordinator.

33. Section 2.9.6.6.1.1 shall be amended by deleting the phrase “/care coordination team”.

2.9.6.6.1.1 For members in CHOICES Group 1, the member's care coordinator may: (1) rely on the plan of care developed by the nursing facility for service delivery instead of developing a plan of care for the member; and (2) supplement the nursing facility plan of care as necessary with the development and implementation of targeted strategies to improve health, functional, or quality of life outcomes (e.g., related to disease management or pharmacy management) or to increase and/or maintain functional abilities. A copy of any supplements to the nursing facility plan of care, and updates to such supplements, shall be maintained by the CONTRACTOR in the member's file.

34. Section 2.9.6.6.2.4 shall be deleted and replaced as follows:

2.9.6.6.2.4 The plan of care developed for CHOICES members in Groups 2 and 3 prior to initiation of CHOICES HCBS shall at a minimum include: (1) pertinent demographic information regarding the member including the name and contact information of any representative and a list of other persons authorized by the member to have access to health care (including long-term care) related information and to assist with assessment, planning,

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and/or implementation of health care (including long-term care) related services and supports; (2) care, including specific tasks and functions, that will be performed by family members and other caregivers; (3) home health, private duty nursing, and long-term care services the member will receive from other payor sources including the payor of such services; (4) home health and private duty nursing that will be authorized by the CONTRACTOR, except in the case of persons enrolled on the basis of Immediate Eligibility who shall have access to services beyond the limited package of CHOICES HCBS (see Section 2.6.1.5.3) only upon determination of categorical and financial eligibility for TennCare; (5) CHOICES HCBS that will be authorized by the CONTRACTOR, including the amount, frequency, duration, and scope (tasks and functions to be performed) of each service to be provided, and the schedule at which such care is needed, as applicable; members enrolled on the basis of Immediate Eligibility shall have access only to a limited package of CHOICES HCBS (see Section 2.6.1.5.3) pending determination of categorical and financial eligibility for TennCare CHOICES however all identified needed services shall be listed in the plan of care; (6) a detailed back-up plan for situations when regularly scheduled HCBS providers are unavailable or do not arrive as scheduled; the back-up plan may include paid and unpaid supports and shall include the names and telephone numbers of persons and agencies to contact and the services provided by listed contacts; the CONTRACTOR shall assess the adequacy of the back-up plan; and (7) for CHOICES Group 2 members, the projected TennCare monthly and annual cost of home health and private duty nursing identified in (4) above, and the projected monthly and annual cost of CHOICES HCBS specified in (5) above, and for CHOICES Group 3 members, the projected total cost of CHOICES HCBS specified in (5) above, excluding the cost of minor home modifications.

35. Section 2.9.6.6.2.5.11 shall be amended by adding the words “eligible CHOICES” in front of the word “HCBS”.

36. Section 2.9.6.6.2.6 shall be amended by adding a new sentence as follows:

2.9.6.6.2.6 The member’s care coordinator/care coordination team shall ensure that the member reviews, signs and dates the plan of care as well as any updates. The care coordinator shall also sign and date the plan of care, along with any updates.

37. Sections 2.9.6.6.2.8 and 2.9.6.6.2.9 shall be deleted and replaced as follows:

2.9.6.6.2.8 Within five (5) business days of completing a reassessment of a member’s needs, the member’s care coordinator shall update the member’s plan of care as appropriate, and the CONTRACTOR shall authorize and initiate CHOICES HCBS in the updated plan of care. The CONTRACTOR shall comply with requirements for service authorization in Section 2.9.6.2.5.10, change of provider in Section 2.9.6.2.5.11, and notice of service delay in Section 2.9.6.2.5.12.

2.9.6.6.2.9 The member’s care coordinator shall inform each member of his/her eligibility end date and educate members regarding the importance of maintaining TennCare CHOICES eligibility, that eligibility must be redetermined at least once a year, and that members receiving CHOICES HCBS will be contacted by TENNCARE or its designee near the date a redetermination is needed to assist them with the process, e.g., collecting appropriate documentation and completing the necessary forms.

38. Section 2.9.6.7.2.1 shall be amended by deleting the phrase “in CHOICES Group 1”.

2.9.6.7.2.1 Members who are waiting for placement in a nursing facility;

39. Sections 2.9.6.8 through 2.9.6.8.22 shall be deleted and replaced as follows:

2.9.6.8 Nursing Facility-to-Community Transition

2.9.6.8.1 The CONTRACTOR shall develop and implement methods for identifying members who may have the ability and/or desire to transition from a nursing facility to the community. Such methods shall include, at a minimum:

2.9.6.8.1.1 Referrals, including but not limited to, treating physician, nursing facility, other providers, community-based organizations, family, and self-referrals;

2.9.6.8.1.2 Identification through the care coordination process, including but not limited to: assessments, information gathered from nursing facility staff or participation in Grand Rounds (as defined in Section 1); and

2.9.6.8.1.3 Review and analysis of members identified by TENNCARE based on Minimum Data Set (MDS) data from nursing facilities.

2.9.6.8.2 For transition referrals by or on behalf of a nursing facility resident, regardless of referral source, the CONTRACTOR shall ensure that within fourteen (14) days of the referral a care coordinator conducts an in-facility visit with the member to determine the member’s interest in and potential ability to transition to the community, and provide orientation and information to the member regarding transition activities. The member’s care coordinator/care coordination team shall document in the member’s case file that transition was discussed with the member and indicate the member’s wishes as well as the member’s potential for transition. The CONTRACTOR shall not require a member to transition when the member expresses a desire to continue receiving nursing facility services.

2.9.6.8.3 For identification by the CONTRACTOR by means other than referral or the care coordination process of a member who may have the ability and/or desire to transition from a nursing facility to the community, the CONTRACTOR shall ensure that within ninety (90) days of such identification a care coordinator conducts an in-facility visit with the member to determine whether or not the member is interested in and potential ability to pursue transition to the community. The member’s care coordinator/care coordination team shall document in the member’s case file that transition was discussed with the member and indicate the member’s wishes as well as the member’s potential for transition. The CONTRACTOR shall not require a member to transition when the member expresses a desire to continue receiving nursing facility services.

2.9.6.8.4 If the member wishes to pursue transition to the community, within fourteen (14) days of the initial visit (see Sections 2.9.6.8.2 and 2.9.6.8.3 above) or within fourteen (14) days of identification through the care coordination process, the care coordinator shall conduct an in-facility assessment of the member’s ability and/or desire to transition using tools and protocols specified or prior approved in writing by TENNCARE. This assessment shall include the identification of any barriers to a safe transition.

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- 2.9.6.8.5 As part of the transition assessment, the care coordinator shall conduct a risk assessment using a tool and protocol specified by TENNCARE, discuss with the member the risk involved in transitioning to the community and shall begin to develop, as applicable, a risk agreement that shall be signed and dated by the member or his/her representative and which shall include identified risks to the member, the consequences of such risks, strategies to mitigate the identified risks, and the member's decision regarding his/her acceptance of risk as part of the plan of care. The risk agreement shall include the frequency and type of care coordinator contacts that exceed the minimum contacts required (see Section 2.9.6.9.4), to mitigate any additional risks associated with transition and shall address any special circumstances due to transition. The member's care coordinator/care coordination team shall also make a determination regarding whether the member's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care. The member's care coordinator shall explain to the member the individual cost neutrality cap and notification process and obtain a signed acknowledgement of understanding by the member or his/her representative that a change in a member's needs or circumstances that would result in the cost neutrality cap being exceeded or that would result in the CONTRACTOR's inability to safely and effectively meet a member's needs in the community and within the cost neutrality cap may result in the member's disenrollment from CHOICES Group 2, in which case, the CONTRACTOR will assist with transition to a more appropriate care delivery setting.
- 2.9.6.8.6 For those members whose transition assessment indicates that they are not candidates for transition to the community, the care coordinator shall notify them in accordance with the specified transition assessment protocol.
- 2.9.6.8.7 For those members whose transition assessment indicates that they are candidates for transition to the community, the care coordinator shall facilitate the development of and complete a transition plan within fourteen (14) days of the member's transition assessment.
- 2.9.6.8.8 The care coordinator shall include other individuals such as the member's family and/or caregiver in the transition planning process if the member requests and/or approves, and such persons are willing and able to participate.
- 2.9.6.8.9 As part of transition planning, prior to the member's physical move to the community, the care coordinator shall visit the residence where the member will live to conduct an on-site evaluation of the physical residence and meet with the member's family or other caregiver who will be residing with the member (as appropriate). The care coordinator shall include in the transition plan activities and/or services needed to mitigate any perceived risks in the residence including but not limited to an increase in face-to-face visits beyond the minimum required contacts in Sections 2.9.6.8.18 and 2.9.6.8.17.
- 2.9.6.8.10 The transition plan shall address all services necessary to safely transition the member to the community and include at a minimum member needs related to housing, transportation, availability of caregivers, and other transition needs and supports. The transition plan shall also identify any barriers to a safe transition and strategies to overcome those barriers.
- 2.9.6.8.11 The CONTRACTOR shall approve the transition plan and authorize any covered or cost effective alternative services included in the plan within ten (10) business days of completion of the plan. The transition plan shall be fully implemented within ninety (90) days from

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approval of the transition plan, except under extenuating circumstances which must be documented in writing.

- 2.9.6.8.12 The member's care coordinator shall also complete a plan of care that meets all criteria described in Section 2.9.6.6 for members in CHOICES Groups 2 and 3 including but not limited to completing a comprehensive needs assessment, completing and signing the risk agreement and making a final determination of cost neutrality. The plan of care shall be authorized and initiated prior to the member's transition to the community.
- 2.9.6.8.13 The CONTRACTOR shall not prohibit a member from transitioning to the community once the member has been counseled regarding risk. However, the CONTRACTOR may determine that the member's needs cannot be safely and effectively met in the community and at a cost that does not exceed nursing facility care. In such case, the CONTRACTOR shall seek written review and approval from TENNCARE prior to denial of any member's request to transition to the community. If TENNCARE approves the CONTRACTOR's request, the CONTRACTOR shall notify the member in accordance with TennCare rules and regulations and the transition assessment protocol, and the member shall have the right to appeal the determination (see Section 2.19.3.12 of this Agreement).
- 2.9.6.8.14 Once completed, the CONTRACTOR shall submit to TENNCARE documentation, as specified by TENNCARE to verify that the member's needs can be safely and effectively met in the community and within the cost neutrality cap. Before transitioning a member the CONTRACTOR shall verify that the member has been approved for enrollment in CHOICES Group 2 effective as of the planned transition date.
- 2.9.6.8.15 The member's care coordinator/care coordination team shall monitor all aspects of the transition process and take immediate action to address any barriers that arise during transition.
- 2.9.6.8.16 For members transitioning to a setting other than a community-based residential alternative setting, the care coordinator/care coordination team shall upon transition utilize the EVV system to monitor the initiation and daily provision of services in accordance with the member's new plan of care, and shall take immediate action to resolve any service gaps (see definition in Section 1).
- 2.9.6.8.17 For members who will live independently in the community or whose on-site visit during transition planning indicated an elevated risk, within the first twenty-four (24) hours, the care coordinator shall visit the member in his/her residence. During the initial ninety (90) day post-transition period, the care coordinator shall conduct monthly face-to-face in-home visits to ensure that the plan of care is being followed, that the plan of care continues to meet the member's needs, and the member has successfully transitioned to the community.
- 2.9.6.8.18 For members transitioning to a community-based residential alternative setting or who will live with a relative or other caregiver, within the first twenty-four (24) hours the care coordinator shall contact the member and within seven (7) days after the member has transitioned to the community, the care coordinator shall visit the member in his/her new residence. During the initial ninety (90) day post-transition period, the care coordinator shall (1) at a minimum, contact the member by telephone each month to ensure that the plan of care is being followed, that the plan of care continues to meet the member's needs, and the member has successfully transitioned to the community; and (2) conduct additional face-to-

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face visits as necessary to address issues and/or concerns and to ensure that the member's needs are met.

- 2.9.6.8.19 The CONTRACTOR shall monitor hospitalizations and nursing facility re-admission for members who transition from a nursing facility to the community to identify issues and implement strategies to improve transition outcomes.
- 2.9.6.8.20 The CONTRACTOR shall be permitted to coordinate or subcontract with local community-based organizations to assist in the identification, planning and facilitation processes related to nursing facility-to-community transitions that are not specifically assigned to the care coordinator.
- 2.9.6.8.21 The CONTRACTOR shall develop and implement any necessary assessment tools, transition plan templates, protocols, or training necessary to ensure that issues that may hinder a member's successful transition are identified and addressed. Any tool, template, or protocol must be prior approved in writing by TENNCARE.
- 2.9.6.8.22 To facilitate nursing facility to community transition, the CONTRACTOR may elect to use specialized transition coordinators or transition teams. All transition activities identified as responsibilities of the care coordinator shall be completed by an individual who meets all of the requirements to be a care coordinator.
- 2.9.6.8.23 The CONTRACTOR shall implement policies and processes necessary to ensure that it is aware when a member is admitted to or discharged from a NF in order to facilitate care planning and as seamless a transition as possible, and to ensure timely notification to TENNCARE and other entities (e.g., DHS) as appropriate.
- 2.9.6.8.23.1 The CONTRACTOR shall require NFs to notify the CONTRACTOR of all NF discharges, transfers between NFs, or elections of hospice services in a NF.
- 2.9.6.8.23.2 The CONTRACTOR shall, in a manner prescribed by TENNCARE notify: a) TENNCARE of all NF discharges and elections of hospice services in a NF; b) DHS of all NF discharges and transfers between NFs; and c) receiving NFs of all applicable level of care information when a member is transferring between NFs.
- 2.9.6.8.23.3 The CONTRACTOR shall conduct a census at least semi-annually at no less than 120-day intervals or as frequently as necessary to confirm the residency status and Group assignment of all CHOICES members (i.e., Group 1 receiving services in a NF or Group 2 receiving HCBS or short-term NF services). The CONTRACTOR shall take actions as necessary to address any discrepancies when a CHOICES member is found to no longer be receiving LTC services, or is receiving services in a different service delivery setting, e.g., NF, HCBS, or hospice in a NF, including, as appropriate, disenrollment from CHOICES and/or enrollment in a different CHOICES Group.
- 2.9.6.8.23.4 The CONTRACTOR shall monitor all short-term NF stays for Group 2 members and shall ensure that the member is transitioned from Group 2 to Group 1 at any time a) it is determined that the stay will not be short-term and the member will not transition back to the community; and b) prior to exhausting the 90-day short-term NF benefit covered for CHOICES Group 2 members.

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- 40. Section 2.9.6.9.1.1 shall be amended by adding a new Section 2.9.6.9.1.1.5 as follows and renumbering the existing Section 2.9.6.9.1.1 accordingly, including any references thereto.**

2.9.6.9.1.1.5 In the manner prescribed by TENNCARE, facilitate transfers between nursing facilities which, at a minimum, includes notification to the receiving facility of the member's level of care, and notification to DHS; and

- 41. The newly renumbered Section 2.9.6.9.1.1.6 shall be amended by adding a new Section 2.9.6.9.1.1.6.5 as follows and renumbering the existing Section 2.9.6.9.1.1.6 accordingly, including any references thereto.**

2.9.6.9.1.1.6.5 Frequent emergency department utilization; or

- 42. Section 2.9.6.9.2.1.2 shall be amended by adding the words "eligible CHOICES" in front of the word "HCBS".**

- 43. Section 2.9.6.9.2.1.5 shall be deleted and replaced as follows:**

2.9.6.9.2.1.5 For members in CHOICES Group 2, each time a member's plan of care is updated to change the level or type of service, document in accordance with TENNCARE policy that the projected total cost of CHOICES HCBS, home health care and private duty nursing is less than the member's cost neutrality cap. If a member's medical condition has changed such that a different cost neutrality cap may be appropriate, the CONTRACTOR shall, in the manner prescribed by TENNCARE, submit to TENNCARE a request to update the member's cost neutrality cap, including documentation specified by TENNCARE to support such request. The CONTRACTOR shall monitor utilization to identify members who may exceed the cost neutrality cap and to intervene as necessary to maintain the member's community placement. The CONTRACTOR shall also educate members in CHOICES Group 2 about the cost neutrality cap and what will happen if the cap is met;

- 44. Sections 2.9.6.9.2.1.6 and 2.9.6.9.2.1.7 shall be amended by adding the word "CHOICES" in front of the word "HCBS".**

- 45. Section 2.9.6.9.2.1.15 shall be amended by adding the words "eligible CHOICES" in front of the word "HCBS".**

- 46. Sections 2.9.6.9.3.1.1 and 2.9.6.9.3.1.1.1 shall be deleted and replaced as follows:**

2.9.6.9.3.1.1 In the manner prescribed by TENNCARE, conduct a level of care reassessment at least annually and within five (5) business days of the CONTRACTOR's becoming aware that the member's functional or medical status has changed in a way that may affect level of care eligibility.

2.9.6.9.3.1.1.1 If the level of care assessment indicates a change in the level of care or if the assessment was prompted by a request by a member, a member's representative or caregiver or another entity for a change in level of services, the level of care shall be forwarded to TENNCARE for determination;

47. Section 2.9.6.9.4.3.2 through 2.9.6.9.4.3.8 shall be deleted and replaced as follows:

- 2.9.6.9.4.3.2 Members who are newly admitted to a nursing facility when the admission has not been authorized or arranged by the CONTRACTOR, shall receive a face-to-face visit from their care coordinator within ten (10) days of notification of admission.
- 2.9.6.9.4.3.3 Members in CHOICES Group 2 who have transitioned from a nursing facility to the community shall be contacted per the applicable timeframe specified in Section 2.9.6.8.
- 2.9.6.9.4.3.4 Within five (5) business days of scheduled initiation of services, the member's care coordinator/care coordination team shall contact members in CHOICES Groups 2 and 3 who begin receiving CHOICES HCBS after the date of enrollment in CHOICES to confirm that services are being provided and that the member's needs are being met (such initial contact may be conducted by phone).
- 2.9.6.9.4.3.5 Within five (5) business days of scheduled initiation of CHOICES HCBS in the updated plan of care, the member's care coordinator/care coordination team shall contact members in CHOICES Groups 2 and 3 to confirm that services are being provided and that the member's needs are being met (such initial contact may be conducted by phone).
- 2.9.6.9.4.3.6 Members in CHOICES Group 1 (who are residents of a nursing facility) shall receive a face-to-face visit from their care coordinator at least twice a year with an interval of at least one-hundred and twenty (120) days between visits.
- 2.9.6.9.4.3.7 Members in CHOICES Group 2 shall be contacted by their care coordinator at least monthly either in person or by telephone with an interval of at least fourteen (14) days between contacts. These members shall be visited in their residence face-to-face by their care coordinator at least quarterly with an interval of at least sixty (60) days between visits.
- 2.9.6.9.4.3.8 Members in CHOICES Group 3 shall be contacted by their care coordinator at least quarterly either in person or by telephone with an interval of at least sixty (60) days between contacts. These members shall be visited in their residence face-to-face by their care coordinator a minimum of two (2) times per year with an interval of at least one-hundred (120) days between visits.

48. Section 2.9.6.9.6.3.3 through 2.9.6.9.6.3.7 shall be deleted and replaced as follows:

- 2.9.6.9.6.3.3 Written confirmation of the member's decision regarding participation in consumer direction of eligible CHOICES HCBS;
- 2.9.6.9.6.3.4 For members in CHOICES Group 2, a completed risk assessment and a risk agreement signed and dated by the member or his/her representative;
- 2.9.6.9.6.3.5 For members in CHOICES Group 2, the cost neutrality cap provided by TENNCARE, and a determination by the CONTRACTOR that the projected cost of CHOICES HCBS, home health, and private duty nursing services will not exceed the member's cost neutrality cap; and

49. Section 2.9.6.9.6.4.1 through 2.9.6.9.6.4.3 shall be deleted and replaced as follows:

- 2.9.6.9.6.4.1 For CHOICES members age 21 and older in Groups 1 and 2, a Freedom of Choice form signed and dated by the member or his/her representative;
- 2.9.6.9.6.4.2 Evidence that a care coordinator provided the member with CHOICES member education materials (see Section 2.17.7 of this Agreement), reviewed the materials, and provided assistance with any questions;
- 2.9.6.9.6.4.3 Evidence that a care coordinator provided the member with education about the member's ability to use an advance directive and documentation of the member's decision;

50. Section 2.9.6.10 through 2.9.6.10.14 shall be deleted and replaced as follows:

- 2.9.6.10 Additional Requirements for Care Coordination Regarding Consumer Direction of eligible CHOICES HCBS
- 2.9.6.10.1 In addition to the roles and responsibilities otherwise specified in this Section 2.9.6, the CONTRACTOR shall ensure that the following additional care coordination functions related to consumer direction of eligible CHOICES HCBS are fulfilled.
- 2.9.6.10.2 The CONTRACTOR shall be responsible for providing all needed eligible CHOICES HCBS using contract providers until all necessary requirements have been fulfilled in order to implement consumer direction of eligible CHOICES HCBS, including but not limited to: the FEA verifies that workers for these services meet all necessary requirements (see Section 2.9.7.6.1 of this Agreement); service agreements are completed and signed; and authorizations for consumer directed services are in place. The CONTRACTOR, in conjunction with the FEA, shall facilitate a seamless transition between contract providers and workers and ensure that there are no interruptions or gaps in services.
- 2.9.6.10.3 If a member elects not to receive eligible CHOICES HCBS using contract providers until all necessary requirements have been fulfilled in order to implement consumer direction of eligible CHOICES HCBS, the CONTRACTOR shall document this decision, including date and member/member's representative's signature, in the manner specified by TENNCARE.
- 2.9.6.10.4 If a member is interested in participating in consumer direction of eligible CHOICES HCBS and the member does not intend to appoint a representative, the care coordinator shall determine the extent to which the member may require assistance to direct his/her services (see Section 2.9.7.4.5). If the care coordinator determines that the member requires assistance to direct his/her services, based upon the results of a completed self-assessment instrument developed by TENNCARE, the care coordinator shall inform the member that he/she will need to designate a representative to assume the consumer direction functions on his/her behalf (see Section 2.9.7.4.5.1).
- 2.9.6.10.5 The member's care coordinator/care coordination team shall ensure that the person identified to serve as the representative meets all qualifications (see Section 2.9.7.2.1) and that a representative agreement is completed and signed by the member prior to forwarding a referral to the FEA (see Section 2.9.7.4.7).

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- 2.9.6.10.6 For members electing to participate in consumer direction, forward to the FEA a referral initiating the member's participation in consumer direction of eligible CHOICES HCBS: (1) within two (2) business days of signing the representative agreement; or (2) if a representative is not designated by the member, within two (2) business days of completion of the self-assessment instrument and the care coordinator determines that the member does not require a representative to assist the member in directing his/her care.
- 2.9.6.10.7 For members electing to participate in consumer direction, the member's care coordinator shall integrate the member's back-up plan for consumer-directed workers (including any updates thereto) into the member's back-up plan for services provided by contract providers, as applicable, and the member's plan of care. The care coordinator shall review the back-up plan developed by the member or his/her representative (as applicable) for consumer direction to determine its adequacy to address the member's needs, and shall monitor for late and missed visits and to ensure that the back-up plan was implemented timely and that the member's needs are being met.
- 2.9.6.10.8 For members electing to participate in consumer direction, the member's care coordinator shall reassess the adequacy of the member's back-up plan for consumer direction on at least an annual basis which shall include any time there are changes in the type, amount, duration, scope of eligible CHOICES HCBS or the schedule at which such services are needed, changes in consumer- directed workers (when such workers also serve as a back-up to other workers) or changes in the availability of paid or unpaid back-up workers to deliver needed care
- 2.9.6.10.9 For members electing to participate in consumer direction, the member's care coordinator shall develop and/or update, as applicable, a risk agreement which takes into account the member's decision to participate in consumer direction, and which identifies any additional risks associated with the member's decision to direct his/her services, the potential consequences of such risk, as well as measures to mitigate these risks. The member's representative (if applicable) shall participate in the risk assessment process. The new or updated risk agreement, as applicable, shall be signed by the member (or the member's representative, as applicable). The CONTRACTOR shall provide a copy of the risk agreement to the member/representative and the FEA.
- 2.9.6.10.10 On an ongoing basis, the CONTRACTOR shall ensure that needs reassessments and updates to the plan of care occur per requirements specified in Sections 2.9.6.9 of this Agreement. The care coordinator shall ensure that, for members participating in consumer direction, the member's supports broker is invited to participate in these meetings.
- 2.9.6.10.11 Within two (2) business days of receipt of the notification from the FEA indicating that all requirements have been fulfilled and the date that the consumer direction can begin for a member, the CONTRACTOR shall forward to the FEA an authorization for consumer directed services for that member. Each authorization for consumer directed services shall include authorized service, authorized units of service, including amount, frequency and duration and the schedule at which services are needed, start and end dates, and service code(s).
- 2.9.6.10.12 The member's care coordinator/care coordination team shall work with and coordinate with a member's supports broker in implementing and monitoring consumer direction of eligible CHOICES HCBS (see Section 2.9.7.3.4).

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- 2.9.6.10.13 The CONTRACTOR shall establish a process that allows for the efficient exchange of all relevant member information between the CONTRACTOR and the FEA.
- 2.9.6.10.14 The care coordinator shall determine a member's interest in enrolling in or continuing to participate in consumer direction annually and shall document the member's decision in the member's plan of care.
- 2.9.6.10.15 If at anytime abuse or neglect is suspected, the member's care coordinator or the FEA shall report the allegations to the CONTRACTOR within 24 hours in accordance with the CONTRACTOR's abuse and neglect plan protocols. The notification shall include at a minimum: the member name; date of allegation reported and/or identified; description of issue; measures taken to mitigate risk; status of reporting to CPS or APS, as appropriate. If the allegation is in reference to a worker or representative, the FEA shall contact the member/representative to immediately release the worker or representative from his/her duties until the investigation is complete. The FEA shall notify the CONTRACTOR regarding this communication with the member/representative and the member or representative's decision. The care coordinator shall work with the member to find a new representative and the FEA shall work with the member to find a suitable replacement worker, if applicable. If the allegations are substantiated as a result of the investigation, the representative or worker shall no longer be allowed to participate in the CHOICES program as a representative or worker. If the investigation is inconclusive, the member may elect to retain the worker or representative. The member's care coordinator, with appropriate assistance from the FEA, shall make any updates to the member's plan of care and/or risk assessment/risk agreement deemed necessary to help ensure the member's health and safety, and the CONTRACTOR may initiate action to involuntary disenroll the member from consumer direction at any time the CONTRACTOR feels that the member's decisions or actions constitute unreasonable risk such that the member's needs can no longer be safely and effectively met in the community while participating in consumer direction.

51. Section 2.9.6.11.5 shall be deleted and replaced as follows:

- 2.9.6.11.5 While care coordination staffing ratios are not specified, the CONTRACTOR shall notify TENNCARE in writing of substantive changes to its Care Coordination Staffing Plan, including a variance of twenty (20) percent or more from the planned staffing ratio. TENNCARE may request changes in the CONTRACTOR's Care Coordination Staffing Plan at any time it determines that the CONTRACTOR does not have sufficient care coordination staff to properly and timely perform its obligations under this Agreement.

52. Sections 2.9.6.11.12 through 2.9.6.11.12.27 shall be deleted and replaced as follows:

- 2.9.6.11.12 The CONTRACTOR shall provide initial training to newly hired care coordinators and ongoing training at least annually to care coordinators. Initial training topics shall include at a minimum:
- 2.9.6.11.12.1 The CHOICES program including a description of the CHOICES groups; eligibility for CHOICES enrollment; enrollment in CHOICES; enrollment targets for Groups 2 and 3, including reserve capacity and administration of waiting lists; and CHOICES benefits, including benefit limits, the individual cost neutrality cap for Group 2, the expenditure

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- cap for Group 3, and the limited benefit package for members enrolled on the basis of Immediate Eligibility;
- 2.9.6.11.12.2 Facilitating CHOICES enrollment for current members;
- 2.9.6.11.12.3 Level of care and needs assessment and reassessment, development of a person-centered plan of care, and updating the plan of care including training on the tools and protocols;
- 2.9.6.11.12.4 Development and implementation of back-up plans;
- 2.9.6.11.12.5 Risk assessment and development of a member-specific risk agreement;
- 2.9.6.11.12.6 Consumer direction of eligible CHOICES HCBS;
- 2.9.6.11.12.7 Self-direction of health care tasks;
- 2.9.6.11.12.8 Coordination of care for duals;

- 2.9.6.11.12.9 Electronic visit verification;
- 2.9.6.11.12.10 Conducting a home visit and use of the monitoring checklist;
- 2.9.6.11.12.11 How to immediately identify and address service gaps;
- 2.9.6.11.12.12 Management of critical transitions (including hospital discharge planning);
- 2.9.6.11.12.13 Nursing facility diversion;
- 2.9.6.11.12.14 Nursing facility to community transitions, including training on tools and protocols;
- 2.9.6.11.12.15 Management of transfers between nursing facilities and CBRA facilities, including adult care homes;
- 2.9.6.11.12.16 Facilitation of transitions between CHOICES Groups;
- 2.9.6.11.12.17 For members in CHOICES Groups 1 and 2, as applicable, members' responsibility regarding patient liability, including the consequences of not paying patient liability;
- 2.9.6.11.12.18 Alzheimer's, dementia and cognitive impairments;
- 2.9.6.11.12.19 Traumatic brain injury;
- 2.9.6.11.12.20 Physical disabilities;
- 2.9.6.11.12.21 Disease management;
- 2.9.6.11.12.22 Behavioral health;
- 2.9.6.11.12.23 Evaluation and management of risk;
- 2.9.6.11.12.24 Identifying and reporting abuse/neglect (see Section 2.24.4);

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- 2.9.6.11.12.25 Critical incident reporting (see Section 2.15.7);
- 2.9.6.11.12.26 Fraud and abuse, including reporting fraud and abuse;
- 2.9.6.11.12.27 Advance directives and end of life care;
- 2.9.6.11.12.28 HIPAA/HITECH;
- 2.9.6.11.12.29 Cultural competency;
- 2.9.6.11.12.30 Disaster planning; and
- 2.9.6.11.12.31 Available community resources for non-covered services.

53. Section 2.9.6.12.1.2 shall be amended by adding the words “level of care” in front of the word “reassessments” as follows:

- 2.9.6.12.1.2 Level of care assessments and level of care reassessments occur on schedule and are submitted to TENNCARE in accordance with requirements in Section 2.9.6.9.3.1.1;

54. Section 2.9.6.12.3 shall be amended by adding the word “CHOICES” in front of the word “HCBS”.

55. Section 2.9.6.12 shall be amended by adding a new Section 2.9.6.12.4 and renumbering the existing Sections accordingly, including any references thereto.

- 2.9.6.12.4 The CONTRACTOR shall require, and shall conduct readiness review activities as necessary to confirm that the EVV system vendor has a plan in place and will be compliant with all ICD-10 requirements in a timely manner;

56. Section 2.9.7 through 2.9.7.1.3.10 shall be deleted and replaced as follows:

2.9.7 Consumer Direction of Eligible CHOICES HCBS

2.9.7.1 General

- 2.9.7.1.1 The CONTRACTOR shall offer consumer direction of eligible CHOICES HCBS to all CHOICES Group 2 and 3 members who are determined by a care coordinator, through the needs assessment/reassessment process, to need attendant care, personal care, homemaker, in-home respite, companion care services and/or any other service specified in TennCare rules and regulations as available for consumer direction. (Companion care is only available for persons electing consumer direction of eligible CHOICES HCBS.) A service that is not specified in TennCare rules and regulations as available for consumer direction or that is not a CHOICES HCBS shall not be consumer directed. Consumer direction in CHOICES affords members the opportunity to have choice and control over how eligible CHOICES HCBS are provided, who provides the services and how much workers are paid for providing care, up to a specified maximum amount established by TENNCARE (see Section 2.9.7.6.11). Member participation in consumer direction of eligible CHOICES HCBS is voluntary. Members may

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elect to participate in or withdraw from consumer direction of eligible CHOICES HCBS at any time, service by service, without affecting their enrollment in CHOICES. To the extent possible, the member shall provide his/her care coordinator ten (10) days advance notice regarding his/her intent to no longer direct one or more eligible CHOICES HCBS or to withdraw from participation in consumer direction of eligible CHOICES HCBS entirely. The CONTRACTOR shall respond to the member's request in keeping with the timeframes and processes set forth in this Section, in order to facilitate a seamless transition to appropriate service delivery. TENNCARE may establish reasonable limitations on the frequency with which members may opt into and out of consumer direction of eligible CHOICES HCBS.

2.9.7.1.2 Consumer direction is a process by which eligible CHOICES HCBS are delivered; it is not a service. If a member chooses not to direct his/her care, he/she shall receive authorized CHOICES HCBS through contract providers. While the denial of a member's request to participate in consumer direction or the termination of a member's participation in consumer direction gives rise to due process including the right to fair hearing, such appeals shall be processed by the TennCare Division of Long Term Care rather than the TennCare Solutions Units, which manages medical appeals pertaining to TennCare benefits (i.e., services).

2.9.7.1.3 Members who participate in consumer direction of eligible CHOICES HCBS choose either to serve as the employer of record of their workers or to designate a representative (see definition below in Section 2.9.7.2.1) to serve as the employer of record on his/her behalf. As the employer of record the member or his/her representative is responsible for the following:

- 2.9.7.1.3.1 Recruiting, hiring and firing workers;
- 2.9.7.1.3.2 Determining workers' duties and developing job descriptions;
- 2.9.7.1.3.3 Scheduling workers;
- 2.9.7.1.3.4 Supervising workers;
- 2.9.7.1.3.5 Evaluating worker performance and addressing any identified deficiencies or concerns;
- 2.9.7.1.3.6 Setting wages from a range of rates established by TENNCARE;
- 2.9.7.1.3.7 Training workers to provide personalized care based on the member's needs and preferences;
- 2.9.7.1.3.8 Ensuring that workers deliver only those services authorized, and reviewing and approving hours worked by consumer-directed workers;
- 2.9.7.1.3.9 Reviewing and ensuring proper documentation for services provided; and
- 2.9.7.1.3.10 Developing and implementing as needed a back-up plan to address instances when a scheduled worker is not available or fails to show up as scheduled.

57. Sections 2.9.7.2.2 and 2.9.7.2.4 shall be amended by adding the words "eligible CHOICES in front of the word "HCBS".

58. Sections 2.9.7.3.2, 2.9.7.3.2.1, 2.9.7.3.3, and 2.9.7.3.11.6 shall be amended by adding the words “eligible CHOICES in front of the word “HCBS”.

59. Section 2.9.7.4 through 2.9.7.4.10.13 shall be deleted and replaced as follows:

2.9.7.4 Needs Assessment/Plan of Care Process

2.9.7.4.1 A CHOICES member may choose to direct needed eligible CHOICES HCBS at anytime: during CHOICES intake, through the needs assessment/reassessment and plan of care and plan of care update processes; and outside of these processes. The care coordinator shall assess the member’s needs for eligible CHOICES HCBS per requirements in Sections 2.9.6.2.4, 2.9.6.3 and 2.9.6.5, as applicable. The care coordinator shall use the plan of care process (including updates) to identify the eligible services that the member will direct and to facilitate the member’s enrollment in consumer direction of eligible CHOICES HCBS.

2.9.7.4.2 The CONTRACTOR shall obtain from the member a signed statement regarding the member’s decision to participate in consumer direction of eligible CHOICES HCBS.

2.9.7.4.2.1 The care coordinator shall assist the member in identifying which of the needed eligible CHOICES HCBS shall be consumer directed, provided by contract providers or a combination of both, in which case, there must be a set schedule which clearly defines when contract providers will be utilized. The CONTRACTOR shall not be expected or required to maintain contract providers “on standby” to serve in a back-up capacity for services a member has elected to receive through consumer direction.

2.9.7.4.3 If the member intends to direct one or more needed eligible CHOICES HCBS, throughout the period of time that consumer direction is being initiated, the CONTRACTOR shall arrange for the provision of needed CHOICES HCBS through contract providers in accordance with 2.9.6. The care coordinator shall obtain from the member his/her choice of contract providers who will provide CHOICES HCBS until such time as workers are secured and ready to begin delivering care through consumer direction.

2.9.7.4.3.1 If a member has been assessed to need companion care services, the CONTRACTOR shall identify non-residential services that will offer interim support to address the member’s needs and assist the member in obtaining contract providers for these services.

2.9.7.4.4 The CONTRACTOR shall be responsible for providing all needed eligible CHOICES HCBS using contract providers, including a back-up plan for such services, until all necessary requirements have been fulfilled in order to implement consumer direction of eligible CHOICES HCBS, including but not limited to: the FEA verifies that workers for these services meet all necessary requirements (see Section 2.9.7.6.1 of this Agreement); service agreements are completed and signed; and authorizations for consumer directed services are in place. The CONTRACTOR, in conjunction with the FEA, shall facilitate a seamless transition between contract providers and workers and ensure that there are no interruptions or gaps in services.

2.9.7.4.5 The care coordinator shall determine if the member will appoint a representative to assume the consumer direction functions on his/her behalf. If the member does not intend to appoint a representative, the care coordinator shall determine the extent to which a member requires assistance to participate in consumer direction of eligible CHOICES HCBS, based upon the

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results of the member's responses to the self-assessment instrument developed by TENNCARE. The self-assessment instrument shall be completed by the member with assistance from the member's care coordinator as appropriate. The care coordinator shall file the completed self-assessment in the member's file.

- 2.9.7.4.5.1 If, based on the results of the self-assessment the care coordinator determines that a member requires assistance to direct his/her services, the care coordinator shall inform the member that he/she will need to designate a representative to assume the consumer direction functions on his/her behalf.
- 2.9.7.4.5.2 The CONTRACTOR shall forward to TENNCARE for disposition, pursuant to TennCare policy, any cases in which the CONTRACTOR plans to deny participation in consumer direction because a care coordinator has determined that the health, safety and welfare of the member would be in jeopardy if the member participates in consumer direction without a representative but the member does not want to appoint a representative to assist in directing his/her services. The CONTRACTOR shall abide by TENNCARE's decision.

- 2.9.7.4.6 The member's care coordinator/care coordination team shall ensure that the person identified to serve as the representative meets all qualifications (see Section 2.9.7.2.1 of this Agreement) and that a representative agreement is completed and signed by the member and the person prior to forwarding a referral to the FEA (see Section 2.9.7.4.7 below).
- 2.9.7.4.7 Within two (2) business days of signing the representative agreement or completion of the self-assessment instrument if the member has not designated a representative and the care coordinator determines that the member does not require a representative to assist the member in directing his/her care, the CONTRACTOR shall forward to the FEA a referral initiating the member's participation in consumer direction of eligible CHOICES HCBS. The referral shall include at a minimum: the date of the referral; the member's name, address, telephone number, and social security number (SSN); the name of the representative and telephone number (if applicable); member's MCO ID number; member's CHOICES enrollment date; eligible selected HCBS, including amount, frequency and duration of each by type; and care coordinator's name and contact information. The CONTRACTOR shall also forward to the FEA a copy of the written confirmation of the member's decision to participate in consumer direction of eligible CHOICES HCBS. Referrals shall be submitted electronically on a daily basis using the agreed upon data interface (either a standard electronic file transfer or the FEA's web portal technology or both) and process. Referrals shall be submitted on a member-by-member basis.
- 2.9.7.4.8 Within two (2) business days of receipt of the referral, the FEA shall assign a supports broker to the member, notify the care coordinator of the assignment and provide the name and contact information of the supports broker.
- 2.9.7.4.9 Within five (5) days of receipt of the referral, the FEA shall contact the member to inform the member of his/her assigned supports broker, provide contact information for the supports broker, and to begin the process of initiating consumer direction of eligible CHOICES HCBS.
- 2.9.7.4.10 *Back-up Plan for Consumer Direction and Updated Risk Assessment/Risk Agreement*
- 2.9.7.4.10.1 The FEA shall assist the member/representative as needed in developing a back-up plan for consumer direction that adequately identifies how the member/representative will

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address situations when a scheduled worker is not available or fails to show up as scheduled. The member/representative (as applicable) shall have primary responsibility for the development and implementation of the back-up plan for consumer directed services.

- 2.9.7.4.10.2 The member/representative (as applicable) may not elect, as part of the back-up plan, to go without services.
- 2.9.7.4.10.3 The back-up plan for consumer direction shall include the names and telephone numbers of contacts (workers, agency staff, organizations, supports) for alternate care, the order in which each shall be notified and the services to be provided by contacts. Back-up contacts may include paid and unpaid supports; however, it is the responsibility of the member electing consumer direction and/or his/her representative to secure paid (as well as unpaid) back-up contacts who are willing and available to serve in this capacity. The CONTRACTOR shall not be expected or required to maintain contract providers “on standby” to serve in a back-up capacity for services a member has elected to receive through consumer direction.

- 2.9.7.4.10.4 All persons and/or organizations noted in the back-up plan for consumer direction shall be contacted by the member/representative to determine their willingness and availability to serve as back-up contacts. The FEA shall confirm with these persons and/or organizations to confirm their willingness and availability to provide care when needed, document confirmation in the member’s file and forward a copy of the documentation to the CONTRACTOR.
- 2.9.7.4.10.5 The member’s care coordinator shall integrate the member’s back-up plan for consumer-directed workers (including any updates thereto) into the member’s back-up plan for services provided by contract providers, as applicable, and the member’s plan of care. The care coordinator shall review the back-up plan developed by the member or his/her representative (as applicable) for consumer direction to determine its adequacy to address the member’s needs, and shall monitor for late and missed visits and to ensure that the back-up plan was implemented timely and that the member’s needs are being met.
- 2.9.7.4.10.6 The FEA shall assist the member or his/her representative (as applicable) in implementing the back-up plan for consumer direction as needed, monitor to ensure that the back-up plan is implemented and effectively working to address the member’s needs, and notify the care coordinator immediately regarding any concerns with the back-up plan or the member’s care.
- 2.9.7.4.10.7 The FEA shall assist the member or his/her representative (as applicable) in reviewing and updating the back-up plan for consumer direction at least annually and as frequently as necessary, which shall include any time there are changes in the type, amount, duration, scope of eligible CHOICES HCBS or the schedule at which such services are needed, changes in workers (when such workers also serve as a back-up to other workers) and changes in the availability of paid or unpaid back-up workers to deliver needed care. As part of the annual review of the back-up plan, the member or his/her representative and the FEA shall confirm that each person specified in the back-up plan continues to be willing and available to serve as back-up workers to deliver needed care and to perform the tasks and functions needed by the member. Any updates to the back-up plan for consumer direction shall be provided to the member’s care coordinator.

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- 2.9.7.4.10.8 The FEA and the CONTRACTOR shall each file a copy of the back-up plan for consumer direction in the member's file.
- 2.9.7.4.10.9 The member's care coordinator shall reassess the adequacy of the member's back-up plan for consumer direction on at least an annual basis which shall include any time there are changes in the type, amount, duration, scope of eligible CHOICES HCBS or the schedule at which such services are needed, changes in consumer-directed workers (when such workers also serve as a back-up to other workers) or changes in the availability of paid or unpaid back-up workers to deliver needed care.
- 2.9.7.4.10.10 The CONTRACTOR shall develop and/or update, as applicable, a risk agreement which takes into account the member's decision to participate in consumer direction, and which identifies any additional risks associated with the member's decision to direct his/her services, the potential consequences of such risk, as well as measures to mitigate these risks. The member/representative shall participate in the process. The member's representative (if applicable) shall participate in the risk assessment process. Once a referral has been made to the FEA for consumer direction, the member's supports broker should be involved in risk assessment and risk planning activities whenever possible. The new or updated risk agreement, as applicable, shall be signed by the member or his/her representative (as applicable). The CONTRACTOR, member/representative and FEA shall receive a copy of the risk agreement. The CONTRACTOR and the FEA shall each file a copy of the risk agreement in the member's file.
- 2.9.7.4.10.11 The FEA shall notify the member's care coordinator immediately when there are changes in the member's needs and/or circumstances which warrant a reassessment of needs and/or risk, or changes to the plan of care or risk agreement.
- 2.9.7.4.10.12 The FEA shall assist the CONTRACTOR in identifying and addressing in the risk assessment and plan of care processes any additional risk associated with the member participating in consumer direction.
- 2.9.7.4.10.13 On an ongoing basis, the CONTRACTOR shall ensure that needs reassessments and updates to the plan of care occur per requirements specified in Sections 2.9.6.9 of this Agreement. The care coordinator shall ensure that the member's supports broker is invited to participate in these meetings.

60. Section 2.9.7.5 through 2.9.7.5.10.1 shall be deleted and replaced as follows:

2.9.7.5 Authorizations for Consumer Directed Services and Service Initiation

- 2.9.7.5.1 Consumer direction of eligible CHOICES HCBS shall not be initiated until all requirements are fulfilled including but not limited to the following: (1) the FEA verifies that the member's employer and related documentation is in order; (2) the FEA verifies that workers meet all qualifications, including participation in required training; (3) there is a signed service agreement specific to each individual worker (see Section 2.9.7.6.6 of this Agreement); and (4) the CONTRACTOR issues to the FEA an authorization for consumer directed services (see 2.9.7.5.6 below) for each service.
- 2.9.7.5.2 The FEA shall work with the member to determine the appropriate level of assistance necessary to recruit, interview and hire workers and provide the assistance.

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- 2.9.7.5.3 Once potential workers are identified, the FEA shall verify that a potential worker meets all applicable qualifications (see Section 2.9.7.6.1 of this Agreement).
- 2.9.7.5.4 The FEA shall ensure that a service agreement is signed between the member or member's representative and his/her worker within five (5) business days following the FEA's verification that a worker meets all qualifications.
- 2.9.7.5.5 The FEA shall periodically update the member's care coordinator of the status of completing required functions necessary to initiate consumer direction, including obtaining completed paperwork from the member/representative and obtaining workers for each identified consumer directed service and any anticipated timeframes by which qualified workers shall be secured and consumer directed services may begin.
- 2.9.7.5.6 The provision of consumer directed services shall begin as soon as possible but no longer than sixty (60) days from the date of the CONTRACTOR's referral to the FEA, except due to circumstances beyond the control of the FEA. Prior to beginning the provision of consumer directed services, the FEA shall notify the CONTRACTOR that all requirements have been fulfilled, including verification of all worker qualifications, criminal background checks, signed service agreements, and that the member is ready to begin consumer direction of eligible CHOICES HCBS. Within two (2) business days of receipt of the notification from the FEA, the CONTRACTOR shall forward to the FEA an authorization for consumer directed services. Each authorization for consumer directed services shall include authorized service; authorized units of service, including amount, frequency and duration and, as appropriate, the schedule at which services are needed; start and end dates; and service code(s). Authorized units of service in a service authorization should reflect the units of measure specified by TENNCARE for the benefit (e.g. visits, hours, days). The CONTRACTOR shall submit authorizations electronically on at least a daily basis using the agreed upon data interface (which may include a standard electronic file transfer, the FEA's web portal technology, the EVV system, or any combination thereof).
- 2.9.7.5.7 If initiation of consumer directed services does not begin within sixty (60) days from the date of the CONTRACTOR's referral to the FEA, the FEA shall contact the CONTRACTOR regarding the cause of the delay and provide appropriate documentation to demonstrate efforts to meet the timeframe. The CONTRACTOR shall determine the appropriate next steps, including but not limited to whether additional time is needed or if the member is still interested in participating in consumer direction of eligible CHOICES HCBS.
- 2.9.7.5.8 Upon the scheduled start date of consumer directed services, the member's care coordinator/care coordination team shall begin monitoring to ensure that services have been initiated and continue to be provided as authorized. This shall include ongoing monitoring via electronic visit verification to ensure that services are provided in accordance with the member's plan of care, including the amount, frequency, duration and scope of each service, in accordance with the member's service schedule. Upon the identification of any gaps in care, the member's care coordinator/care coordination team shall contact the FEA who shall assist the member or his/her representative as needed in implementing the member's back-up plan for consumer direction.
- 2.9.7.5.9 Within five (5) business days of the scheduled start date of consumer directed services as specified in the authorization of consumer directed services, a member of the care coordinator

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team shall contact the member or his/her representative to confirm that services are being provided and that the member's needs are being met.

2.9.7.5.10 On an ongoing basis, in addition to requirements specified above in 2.9.7.5.3 – 2.9.7.5.9 above:

2.9.7.5.10.1 The CONTRACTOR shall develop and forward to the FEA a new authorization for consumer directed services when the following occur: a change in the number of service units, or the frequency or duration of service delivery, or a change in the schedule at which services are needed; or a change in the services to be provided through consumer direction, including the provision of a new service through consumer direction or termination of a service through consumer direction.

61. Sections 2.9.7.7.1, 2.9.7.7.4.1, and 2.9.7.8.5 shall be amended by adding the words “eligible CHOICES” in front of the word “HCBS”.

62. Section 2.9.7.9 through 2.9.7.9.9 shall be amended by adding the words “eligible CHOICES” in front of the word “HCBS” and by adding the words “outbound 834” in front of the words “enrollment file”.

63. Section 2.9.7.9.10.2 shall be amended by adding the words “eligible CHOICES” in front of the word “HCBS.”

64. Section 2.9.14.6 shall be deleted and replaced and Section 2.9.14.7 shall be deleted in its entirety and the remaining Section 2.9.14 shall be renumbered accordingly, including any references thereto.

2.9.14.6 Area Agencies on Aging and Disability (AAADs) regarding intake of members new to both TennCare and CHOICES, and assisting CHOICES members in Groups 2 and 3 with the TennCare eligibility redetermination process;

65. Section 2.11.1.4.1 shall be amended by adding the word “CHOICES” in front of the word “HCBS”.

66. Section 2.11.1.8.2 shall be amended by deleting the phrase “, including services”.

2.11.1.8.2 The CONTRACTOR is not required to provide non-emergency transportation for HCBS provided through a 1915(c) waiver program for persons with intellectual disabilities (i.e., mental retardation) and HCBS provided through the CHOICES program, except as provided in Section 2.11.1.8.1 above.

67. Section 2.11.6.3, 2.11.6.4, 2.11.6.6.2, 2.11.6.6.5, 2.11.6.6.7 and 2.11.6.6.8 shall be amended by adding the word “CHOICES” in front of the word HCBS.

68. Section 2.11.8.4 through 2.11.8.4.2 shall be deleted and replaced as follows:

2.11.8.4 Credentialing of Long-Term Care Providers

2.11.8.4.1 The CONTRACTOR shall develop and implement a process for credentialing and recredentialing long-term care providers. The CONTRACTOR's process shall, as applicable, meet the minimum NCQA requirements as specified in the NCQA Standards and Guidelines for the Accreditation of MCOs. In addition, the CONTRACTOR shall ensure that all long-term care providers, including those credentialed/recruited in accordance with NCQA Standards and Guidelines for the Accreditation of MCOs, meet applicable State requirements, as specified by TENNCARE in State Rule, this Agreement, or in policies or protocols.

2.11.8.4.1.1 The CONTRACTOR shall develop policies that specify by HCBS provider type the credentialing process, the recredentialing process including frequency, and ongoing provider monitoring activities.

2.11.8.4.1.1.1 Ongoing CHOICES HCBS providers must be recredentialed at least annually;

2.11.8.4.1.1.2 All other CHOICES HCBS providers (e.g., pest control and assistive technology), must be recredentialed, at a minimum, every three (3) years.

2.11.8.4.1.2 At a minimum, credentialing of LTC providers shall include the collection of required documents, including disclosure statements, and verification that the provider:

2.11.8.4.1.2.1 Has a valid license or certification for the services it will contract to provide as required pursuant to State law or rule, or TENNCARE policies or protocols;

2.11.8.4.1.2.2 Is not excluded from participation in the Medicare or Medicaid programs;

2.11.8.4.1.2.3 Has a National Provider Identifier (NPI) Number, where applicable, and has obtained a Medicaid provider number from TENNCARE.

2.11.8.4.1.2.4 Has policies and processes in place to conduct, in accordance with Federal and State law and rule and TENNCARE policy, criminal background checks, which shall include a check of the Tennessee Abuse Registry, Tennessee Felony Offender Registry, National and Tennessee Sexual Offender Registry, and List of Excluded Individuals/Entities (LEIE), on all prospective employees who will deliver CHOICES HCBS and to document these in the worker's employment record;

2.11.8.4.1.2.5 Has a process in place to provide and document initial and ongoing education to its employees who will provide services to CHOICES members that includes, at a minimum:

2.11.8.4.1.2.5.1 Caring for Elderly and Disabled population;

2.11.3.4.1.2.5.2 Abuse and neglect prevention, identification and reporting;

2.11.3.4.1.2.5.3 Critical incident reporting;

2.11.3.4.1.2.5.4 Documentation of service delivery;

2.11.3.4.1.2.5.5 Use of the EVV System; and

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- 2.11.8.4.1.2.5.6 Any other training requirements specified by TENNCARE in State Rule, this Agreement, or in policies or protocols.
 - 2.11.8.4.1.2.6 Has policies and processes in place to ensure:
 - 2.11.8.4.1.2.6.1 Compliance with the CONTRACTOR’s critical incident reporting and management process; and
 - 2.11.8.4.1.2.6.2 Appropriate use of the EVV system.
 - 2.11.8.4.1.3 At a minimum, recredentialing of HCBS providers shall include verification of continued licensure and/or certification (as applicable), and compliance with policies and procedures identified during credentialing, including background checks and training requirements, critical incident reporting and management, and use of the EVV.
 - 2.11.8.4.1.4 For both credentialing and recredentialing processes, the CONTRACTOR shall conduct a site visit, unless the provider is located out of state, in which case the CONTRACTOR may waive the site visit and document the reason in the provider file.
 - 2.11.8.4.1.5 At a minimum, the CONTRACTOR shall reverify monthly that each HCBS provider has not been excluded from participation in the Medicare or Medicaid, and/or SCHIP programs.
- 69. Section 2.12.9.38 shall be amended by adding the word “CHOICES” in front of the word “HCBS”.**
- 70. Section 2.12.9 shall be amended by adding a new Section 2.12.9.63 as follows:**
- 2.12.9.63 The provider, subcontractor or any other entity agrees to abide by the Medicaid laws, regulations and program instructions that apply to the provider. The provider, subcontractor or any other entity understands that payment of a claim by TennCare or a TennCare Managed Care Contractor and/or Organization is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and is conditioned on the provider’s , subcontractor’s or any other entity’s compliance with all applicable conditions of participation in Medicaid. The provider, subcontractor or any other entity understands and agrees that each claim the provider, subcontractor or any other entity submits to TennCare or a TennCare Managed Care Contractor and/or Organization constitutes a certification that the provider, subcontractor or any other entity has complied with all applicable Medicaid laws, regulations and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), in connection with such claims and the services provided therein.

71. Sections 2.12.12 through 2.12.12.10 and Section 2.12.13 shall be deleted and replaced as follows:

- 2.12.12 The provider agreement with a CHOICES HCBS provider shall meet the minimum requirements specified in Section 2.12.9 above and shall also include, at a minimum, the following requirements:
 - 2.12.12.1 Require the CHOICES HCBS provider to provide at least thirty (30) days advance notice to the CONTRACTOR when the provider is no longer willing or able to provide services to a member, including the reason for the decision, and to cooperate with the member's care coordinator to facilitate a seamless transition to alternate providers;
 - 2.12.12.2 In the event that a CHOICES HCBS provider change is initiated for a member, require that, regardless of any other provision in the provider agreement, the transferring HCBS provider continue to provide services to the member in accordance with the member's plan of care until the member has been transitioned to a new provider, as determined by the CONTRACTOR, or as otherwise directed by the CONTRACTOR, which may exceed thirty (30) days from the date of notice to the CONTRACTOR;
 - 2.12.12.3 Specify that reimbursement of a CHOICES HCBS provider shall be contingent upon the provision of services to an eligible member in accordance with applicable federal and state requirements and the member's plan of care as authorized by the CONTRACTOR, and must be supported by detailed documentation of service delivery to support the amount of services billed, including at a minimum, the date, time and location of service, the specific HCBS provided, the name of the member receiving the service, the name of the staff person who delivered the service, the detailed tasks and functions performed as a component of each service, notes for other caregivers (whether paid or unpaid) regarding the member or his/her needs (as applicable), and the initials or signature of the staff person who delivered the service;
 - 2.12.12.4 Require CHOICES HCBS providers to immediately report any deviations from a member's service schedule to the member's care coordinator;
 - 2.12.12.5 Require CHOICES HCBS providers to use the electronic visit verification system specified by the CONTRACTOR in accordance with the CONTRACTOR's requirements;
 - 2.12.12.6 Require that upon acceptance by the CHOICES HCBS provider to provide approved services to a member as indicated in the member's plan of care, the provider shall ensure that it has staff sufficient to provide the service(s) authorized by the CONTRACTOR in accordance with the member's plan of care, including the amount, frequency, duration and scope of each service in accordance with the member's service schedule;
 - 2.12.12.7 Require CHOICES HCBS providers to provide back-up for their own staff if they are unable to fulfill their assignment for any reason and ensure that back-up staff meet the qualifications for the authorized service;
 - 2.12.12.8 Prohibit CHOICES HCBS providers from requiring a member to choose the provider as a provider of multiple services as a condition of providing any service to the member;

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- 2.12.12.9 Prohibit CHOICES HCBS providers from soliciting members to receive services from the provider including:
 - 2.12.12.9.1 Referring an individual for CHOICES screening and intake with the expectation that, should CHOICES enrollment occur, the provider will be selected by the member as the service provider; or
 - 2.12.12.9.2 Communicating with existing CHOICES members via telephone, face-to-face or written communication for the purpose of petitioning the member to change CHOICES providers;
- 2.12.12.10 Require CHOICES HCBS providers to comply with critical incident reporting and management requirements (see Section 2.15.7 of this Agreement); and
- 2.12.12.11 Shall not require the CHOICES HCBS provider to have liability insurance in excess of TENNCARE requirements in effect prior to the implementation of CHOICES.
- 2.12.13 The provider agreement with a CHOICES HCBS provider to provide PERS, assistive technology, minor home modifications, or pest control shall meet the requirements specified in Sections 2.12.9, 2.12.10, and 2.12.12 except that these provider agreements shall not be required to meet the following requirements: Section 2.12.9.9 regarding emergency services; Section 2.12.9.11 regarding delay in prenatal care; Section 2.12.9.12 regarding CLIA; Section 2.12.9.38 regarding hospital protocols; Section 2.12.9.40 regarding reimbursement of obstetric care; Section 2.12.9.52.2 regarding prior authorization of pharmacy; and Section 2.12.9.53 regarding coordination with the PBM.

72. Sections 2.13.4 through 2.13.4.3 and Sections 2.13.5 through 2.13.5.4 shall be deleted and replaced as follows:

2.13.4 Nursing Facility Services

- 2.13.4.1 The CONTRACTOR shall reimburse contract nursing facility providers at the per diem rate specified by TENNCARE, net of any applicable patient liability amount (see Section 2.6.7).
- 2.13.4.2 The CONTRACTOR shall reimburse non-contract nursing facility providers as specified in TennCare rules and regulations, net of any applicable patient liability amount (see Section 2.6.7).
- 2.13.4.3 If, prior to the end date specified by TENNCARE in its approval of Level II nursing facility services, the CONTRACTOR determines that the nursing facility is providing Level I and not Level II nursing facility services, the CONTRACTOR shall notify TENNCARE and, as appropriate, shall submit a request to modify the member's level of nursing facility services. The CONTRACTOR shall submit documentation as specified by TENNCARE to support the request. The CONTRACTOR may reimburse the nursing facility for the lesser level of services only when such lesser level of services is billed by the nursing facility or upon approval from TENNCARE of a reduction in the member's level of care or reimbursement as reflected on the outbound 834 enrollment file.
- 2.13.4.4 The CONTRACTOR shall, upon receipt of notification from TENNCARE of a retrospective adjustment of a nursing facility's per diem rate(s), without requiring any action on the part of the provider, reprocess affected claims and provide any additional payment due within sixty

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(60) days of receipt of such notification. The CONTRACTOR shall, upon notification in the outbound 834 enrollment file of retroactive patient liability amounts or retroactive adjustments in patient liability amounts, without requiring any action on the part of the provider, reprocess affected claims and provide any additional payment due within thirty (30) days of receipt of such notification. The CONTRACTOR shall not require that NFs resubmit affected claims in order to process these adjustments.

2.13.5 CHOICES HCBS

- 2.13.5.1 For covered CHOICES HCBS and for CHOICES HCBS that exceed the specified benefit limit and are provided by the CONTRACTOR as a cost effective alternative (see Section 2.6.5), the CONTRACTOR shall reimburse contract HCBS providers, including community-based residential alternatives, at the rate specified by TENNCARE.
- 2.13.5.2 The CONTRACTOR shall reimburse non-contract CHOICES HCBS providers as specified in TennCare rules and regulations.
- 2.13.5.3 For other HCBS that are not otherwise covered but are offered by the CONTRACTOR as a cost effective alternative to nursing facility services (see Section 2.6.5), the CONTRACTOR shall negotiate the rate of reimbursement.
- 2.13.5.4 The CONTRACTOR shall reimburse consumer-directed workers in accordance with Sections 2.9.6.7 and 2.26 of this Agreement.

- 73. Section 2.13 shall be amended by adding a new Section 2.13.9 as follows and renumbering the existing Section 2.13.9 through 2.13.23 accordingly, including any references thereto.**

2.13.9 Federally Qualified Health Centers and Rural Health Clinics (FQHCs/RHCs)

Upon notification by TENNCARE, the CONTRACTOR shall reimburse contracted FQHCs/RHCs using prospective payment system rates and wraparound payments for qualifying visits in accordance with TENNCARE developed policies and protocols. TENNCARE's policies and protocols shall be based on federal regulations.

- 74. The renumbered Sections 2.13.12.3 and 2.13.13.3 shall be amended by adding the words "outbound 834" in front of the words "enrollment file".**
- 75. The renumbered Section 2.13.14 shall be amended by adding the phrase "in accordance with the requirements of this agreement" to the end of the last sentence.**

2.13.14 Medically Necessary Services Obtained from Non-Contract Provider Referred by Contract Provider

The CONTRACTOR shall pay for any medically necessary covered services provided to a member by a non-contract provider at the request of a contract provider. The CONTRACTOR's payment shall not be less than eighty percent (80%) of the rate that would have been paid by the CONTRACTOR if the member had received the services from a contract provider. The CONTRACTOR shall only pay for covered long-term care services for which the member was eligible (see Section 2.6) and that were authorized by the CONTRACTOR in accordance with the requirements of this agreement.

76. The renumbered Section 2.13.22 shall be amended by adding the phrase “eligible CHOICES” in front of the word “HCBS”.

77. Section 2.14.1.12 through 2.14.1.12.2 shall be deleted and replaced as follows:

2.14.1.12 Nursing Facility

2.14.1.12.1 The CONTRACTOR shall ensure that reimbursement of level II nursing facility care is provided for CHOICES members who have been determined by TENNCARE to be eligible for Level II nursing facility care for the period specified by TENNCARE, except when a lesser level of services is billed by the nursing facility. The CONTRACTOR shall monitor the member’s condition, and if the CONTRACTOR determines that, prior to the end date specified by TENNCARE, the member no longer requires Level II nursing facility care, the CONTRACTOR may submit to TENNCARE a request to modify the member’s level of nursing facility services. The CONTRACTOR shall submit documentation as specified by TENNCARE to support the request. The CONTRACTOR may reimburse the nursing facility for the lesser level of services only when such lesser level of services is billed by the nursing facility or upon approval from TENNCARE of a reduction in the member’s level of care or reimbursement as reflected on the outbound 834 enrollment file. .

78. Section 2.14.5 through 2.14.5.4 shall be deleted and replaced as follows:

2.14.5 **Authorization of Long-Term Care Services**

2.14.5.1 The CONTRACTOR shall have in place an authorization process for covered long-term care services and cost effective alternative services that is separate from but integrated with the CONTRACTOR’s prior authorization process for covered physical health and behavioral health services (See section 2.9.6 of this Agreement).

2.14.5.2 The CONTRACTOR may decide whether it will issue service authorizations for nursing facility services, or whether it will instead process claims for such services in accordance with the level of care and/or reimbursement (including the duration of such level of care and/or reimbursement) approved by TENNCARE (see Section 2.14.1.12), except that the CONTRACTOR may reimburse a lesser level of service when such lesser level of service is billed by the facility.

2.14.5.3 The CONTRACTOR shall authorize and initiate CHOICES HCBS for CHOICES members within the timeframes specified in Sections 2.9.2, 2.9.3, and 2.9.6 of this Agreement.

2.14.5.4 The CONTRACTOR shall not require that CHOICES HCBS be ordered by a treating physician, but may consult with the treating physician as appropriate regarding the member’s physical health, behavioral health, and long-term care needs and in order to facilitate communication and coordination regarding the member’s physical health, behavioral health, and long-term care services.

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- 2.14.5.5 For non-CHOICES members receiving care in non-contract nursing facilities authorized by the CONTRACTOR as a cost-effective alternative, the CONTRACTOR shall reimburse services in accordance with its authorization until such time that the member is no longer eligible for services, is enrolled in CHOICES, or such care is no longer medically necessary or cost-effective.

79. Section 2.14.8.1 shall be deleted and replaced as follows:

- 2.14.8.1 The CONTRACTOR is responsible for eliciting pertinent medical history information from the treating provider(s), as needed, for purposes of making medical necessity determinations. With respect to CHOICES HCBS which are not primarily medical in nature, pertinent medical history shall include assessments, case notes, and documentation of service delivery by HCBS providers. Medical information from the treating physician may also be pertinent in better understanding the member's functional needs. The CONTRACTOR shall take action (e.g., sending a CONTRACTOR representative to obtain the information and/or discuss the issue with the provider, imposing financial penalties against the provider, etc.), to address the problem if a treating provider is uncooperative in supplying needed information. The CONTRACTOR shall make documentation of such action available to TENNCARE, upon request. Providers who do not provide requested information for purposes of making a medical necessity determination for a particular item or service shall not be entitled to payment for the provision of such item or service.

80. Section 2.15.1.6 shall be amended by adding new Sections 2.15.1.6.1 through 2.15.1.6.3 as follows.

- 2.15.1.6 The CONTRACTOR shall take appropriate action to address service delivery, provider, and other QM/QI issues as they are identified.
 - 2.15.1.6.1 The CONTRACTOR may be required to conduct special focus studies as requested by TENNCARE.
 - 2.15.1.6.2 The CONTRACTOR shall collect data on race and ethnicity. As part of the QM/QI program description, the CONTRACTOR shall include the methodology utilized for collecting the data, as well as any interventions taken to enhance the accuracy of the data collected.
 - 2.15.1.6.3 The CONTRACTOR shall include QM/QI activities to improve healthcare disparities identified through data collection.

81. Section 2.15.4 shall be deleted and replaced as follows:

2.15.4 Clinical Practice Guidelines

The CONTRACTOR shall utilize evidence-based clinical practice guidelines in its disease management programs. The guidelines shall be reviewed and revised whenever the guidelines change and at least every two (2) years.

82. Section 2.15.6 shall be amended by adding a new Section 2.15.6.3 as follows:

- 2.15.6.3 The CONTRACTOR shall submit annually the Relative Resource Use (RRU) data to TENNCARE within ten (10) business days of receipt from NCQA. The CONTRACTOR shall submit both the Regional and National RRU results.

83. Sections 2.15.7 through 2.15.7.6 shall be amended by adding the word “CHOICES” in front of the word “HCBS”.

84. Section 2.17.2 shall be amended by adding a new Section 2.17.2.10 as follows:

2.17.2.10 All educational materials (brochures, scripts etc.) shall be reviewed and updated concurrently with the update of the Clinical Practice Guidelines to assure the materials reflect current evidence-based information.

85. Section 2.17.4.6, 2.17.4.7.15 and 2.17.7.3.22 shall be amended by adding the words “eligible CHOICES” in front of the word “HCBS”.

86. Section 2.17.7.3.2, 2.17.7.3.10, 2.17.7.3.15, 2.17.7.3.16, 2.17.7.3.18, 2.17.7.3.19 and 2.17.8.6 shall be amended by adding the word “CHOICES” in front of the word “HCBS”.

87. Section 2.18.4.6 shall be deleted and replaced as follows:

2.18.4.6 The provider service line shall be adequately staffed with staff trained to accurately respond to questions regarding the TennCare program and the CONTRACTOR’s MCO, including but not limited to, covered services, the CHOICES program, TENNderCare, prior authorization and referral requirements, care coordination, and the CONTRACTOR’s provider network. For a period of at least twelve (12) months following the implementation of CHOICES in the Grand Region covered by this Agreement, the CONTRACTOR shall maintain a dedicated queue to assist long-term care providers with enrollment, service authorization, or reimbursement questions or issues and shall ensure that long-term care providers are appropriately notified regarding how to access the dedicated queue for assistance. Such period may be extended as determined necessary by TENNCARE.

88. Section 2.18.5.3.3 shall be deleted and replaced as follows:

2.18.5.3.3 Description of the CHOICES program including but not limited to who qualifies for CHOICES (including the three CHOICES groups and enrollment targets for CHOICES Groups 2 and 3); how to enroll in CHOICES; long-term care services available to each CHOICES Group (including benefit limits, cost neutrality cap for members in Group 2, and the expenditure cap for members in Group 3); consumer direction of eligible CHOICES HCBS; self-direction of health care tasks; the level of care assessment and reassessment process; the needs assessment and reassessment processes; requirement to provide services in accordance with an approved plan of care including the amount, frequency, duration and scope of each service in accordance with the member’s service schedule; service authorization requirements and processes; the role of the care coordinator; the role and responsibilities of long-term care and other providers; requirements regarding the electronic visit verification system and the provider’s responsibility in monitoring and immediately addressing service gaps, including back-up staff; how to submit clean claims; and documentation requirements for CHOICES HCBS providers;

89. Section 2.18.5.3.13 shall be amended by adding the word “CHOICES” in front of the word “HCBS”.

- 90. Section 2.18.5.3 shall be amended by adding a new Section 2.18.5.3.14 and renumbering the existing Section accordingly, including any references thereto.**

2.18.5.3.14 Information for CHOICES HCBS providers regarding prohibition of facilitating CHOICES referrals with the expectation of being selected as the service provider or petitioning existing CHOICES members to change CHOICES providers.

- 91. Section 2.18.6.3.16 shall be amended by adding the word “CHOICES” in front of the word “HCBS”.**

- 92. Section 2.18.6 shall be amended by adding a new Section 2.18.6.5 and renumbering the existing Section accordingly, including any references thereto.**

2.18.6.5 The CONTRACTOR shall develop and implement a training plan to educate long-term care providers regarding compliance with ICD-10 requirements;

- ~~**93. The renumbered Sections 2.18.6.7 and 2.18.6.8 shall be amended by adding the word “CHOICES” in front of the word “HCBS”.**~~

~~2.18.6.7 For a period of at least twelve (12) months following the implementation of CHOICES in the Grand Region covered by this Agreement, the CONTRACTOR shall conduct monthly education and training for CHOICES HCBS providers regarding the use of the EVV system. Such period may be extended as determined necessary by TENNCARE.~~

~~2.18.6.8 The CONTRACTOR shall provide education and training on documentation requirements for CHOICES HCBS.~~

- 94. Section 2.21.5 through 2.21.5.2 shall be deleted and replaced as follows:**

2.21.5 Patient Liability

2.21.5.1 TENNCARE will notify the CONTRACTOR of any applicable patient liability amounts for members via the outbound 834 enrollment file.

2.21.5.2 The CONTRACTOR shall delegate collection of patient liability to the nursing facility or community-based residential alternative facility and shall pay the facility net of the applicable patient liability amount. For members in CHOICES Groups 2 or 3 receiving non-residential CHOICES HCBS, the CONTRACTOR shall collect applicable patient liability amounts.

2.21.5.3 When TENNCARE notifies the CONTRACTOR of patient liability amounts for CHOICES members via the outbound 834 enrollment file at any time other than the beginning of the month, then the CONTRACTOR shall determine and apply the prorated portion of patient liability for that month.

- 95. Section 2.22.4.4 through 2.22.4.4.2 shall be amended by adding the word “CHOICES” in front of the word “HCBS”.**

- 96. Section 2.22.6.3 and 2.22.6.4.13 shall be amended by adding the word “CHOICES” in front of the word “HCBS”.**

97. Section 2.22.6.4.5 shall be deleted and replaced as follows:

2.22.6.4.5 Allowed payment amount agrees with contracted rate and the terms of the provider agreement;

98. Section 2.22.7.1.8 shall be amended by adding the word “CHOICES” in front of the word “HCBS”.

99. Section 2.23.5.1 shall be amended by adding the words “outbound 834” in front of the words “enrollment files”.

100. Section 2.23.13.1 shall be amended by adding the words “outbound 834” in front of the words “enrollment file”.

101. Section 2.24.3.2 shall be amended by adding the word “CHOICES” in front of the word “HCBS”.

102. Section 2.26.6 shall be amended by adding the words “eligible CHOICES” in front of the word “HCBS”.

103. Section 2.29.1 shall be amended by adding a new Section 2.29.1.11 as follows:

2.29.1.11 The CONTRACTOR shall be required to have appropriate staff member(s) attend certain on-site meetings held at TennCare offices or at other sites as requested and designated by TENNCARE.

104. Sections 2.29.2 through 2.29.2.2 shall be deleted and replaced as follows:

2.29.2 Licensure and Background Checks

2.29.2.1 Except as specified in this Section 2.29.2.1 regarding the FEA, the CONTRACTOR is responsible for ensuring that all persons, whether they are employees, agents, subcontractors, providers or anyone acting for or on behalf of the CONTRACTOR, are legally authorized to render services under applicable state law. The FEA shall be responsible for ensuring that consumer-directed workers are qualified to provide eligible CHOICES HCBS in accordance with TENNCARE requirements.

2.29.2.2 Except as specified in this Section 2.29.2.2 regarding the FEA, the CONTRACTOR is responsible for conducting background checks in accordance with state law and TennCare policy and ensuring that all employees, agents, subcontractors, providers or anyone acting for or on behalf of the CONTRACTOR conducts background checks in accordance with state law and TennCare policy. At a minimum, background checks shall include a check of the Tennessee Abuse Registry, Tennessee Felony Offender Registry, National and Tennessee Sexual Offender Registry, and List of Excluded Individuals/Entities (LEIE). The FEA shall be responsible for conducting background checks on its staff, its subcontractors, and consumer-directed workers.

105. Section 2.30.1.4 shall be deleted and replaced as follows:

2.30.1.4 The CONTRACTOR shall submit all reports electronically and in the manner and format prescribed by TENNCARE and shall ensure that all reports are complete and accurate. The CONTRACTOR shall be subject to liquidated damages as specified in Section 4.20.2.1.1 for reports determined to be late, incorrect, incomplete or deficient, or not submitted in the manner and format prescribed by TENNCARE until all deficiencies have been corrected. Except as otherwise specified by TENNCARE, all reports shall be specific to the Grand Region covered by this Agreement.

106. The lead in paragraph of Section 2.30.6.5 shall be deleted and replaced as follows:

2.30.6.5 The CONTRACTOR shall submit a monthly *CHOICES HCBS Late and Missed Visits Report* for CHOICES members regarding the following CHOICES HCBS: personal care, attendant care, homemaker services, and home-delivered meals. The report shall include information on specified measures, which shall include but not be limited to the following:

107. Item (2) of Section 2.30.6.6 shall be amended by adding the words “eligible CHOICES” in front of the word “HCBS”.

108. Section 2.30.7.1 shall be amended by adding the word “CHOICES” in front of the word “HCBS”.

109. Section 2.30.7.5 shall be deleted and replaced as follows:

2.30.7.5 The CONTRACTOR shall submit an *Annual Plan for the Monitoring of Behavioral Health Appointment Timeliness* that shall include the CONTRACTOR’s plan for monitoring behavioral health providers to ensure that they comply with the timeliness of appointment standards that are outlined for behavioral health in Attachment III for routine specialty MD (behavioral health) care and Attachment V for Outpatient Non-MD behavioral health services. This plan will be submitted for approval to the Bureau of TennCare by December 31 of each year and shall identify methods for determining how they will monitor and evaluate providers for compliance, develop corrective action plans for compliance, maintain records of audits for timeliness and describe efforts to improve timeliness of appointments. The minimum data elements required are identified in Attachment IX, Exhibit D.

110. Section 2.30.7 shall be amended by adding a new Section 2.30.7.6 and renumbering the existing Sections 2.30.7.6 and 2.30.7.7 accordingly, including any references thereto.

2.30.7.6 The CONTRACTOR shall submit a *Quarterly Behavioral Health Appointment Timeliness Summary Report* that includes a quarterly summary of activities based on the Annual Plan for Monitoring of Behavioral Health Appointment Timeliness (See Section 2.30.7.5) The minimum data elements required are identified in Attachment IX, Exhibit D.

111. Section 2.30.9 shall be amended by adding a new Section 2.30.9.5 as follows:

2.30.9.5 Upon notification by TENNCARE, the CONTRACTOR shall submit a weekly *Administrative Services Only Invoice Report* for all payments to clinics designated as Federally Qualified Health Clinics or Rural Health Clinics.

112. Section 2.30.11 shall be amended by adding a new Section 2.30.11.7 as follows:

2.30.11.7 By October 1, 2011, the CONTRACTOR is required to submit a *Data Collection Strategy Report* that describes how they intend to collect data in accordance with the HHS initiative to implement a multifaceted health disparities data collection strategy. (HHS Action Plan to Reduce Racial and Ethnic Health Disparities, April 8, 2011) The report must include the CONTRACTOR's plans for collection and reporting of data in five specific demographic categories in accordance with the new provisions of the Affordable Care Act: race, ethnicity, gender, primary language, and disability status. The following OMB (minimum standards) categories for race and ethnicity (Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity, 1997) must be used: Hispanic or Latino or Not Hispanic or Latino; American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, and White. CONTRACTOR plans must also include how the collected data will be used to integrate information across systems in order to enhance TennCare data, any system changes that will be needed, and timelines for implementation. Following review of the CONTRACTOR's plan, TENNCARE will set an implementation date for revised data collection and data reporting.

113. Item (2) of Section 2.30.16.4 shall be amended by adding the word "CHOICES" in front of the word "HCBS".

114. Section 4.8.1 shall be deleted and replaced as follows:

4.8.1 In no event shall the maximum liability of the State under this Agreement during the original term of the Agreement exceed two billion, two hundred seventy four million, eight hundred ninety seven thousand, one hundred five dollars and ninety cents (\$2,274,897,105.90).

115. The opening paragraph of Section 5.1 shall be deleted and replaced as follows:

5.1 NOTICE

All notices required to be given under this Agreement shall be given in writing, and shall be sent by United States certified mail, postage prepaid, return receipt requested; in person; by facsimile, email or other electronic means, including but not limited to providing notice through computer databases, software or other systems made available to the CONTRACTOR by TENNCARE; or by other means, so long as proof of delivery and receipt is given, and the cost of delivery is borne by the notifying party, to the appropriate party at the address given below, or at such other address (or addresses) as may be provided by notice given under this Section.

116. Section 5.2.1 shall be amended by deleting and replacing “June 30, 2011” with June 30, 2012” as follows:

5.2.1 This Agreement, and its incorporated attachments, if any, as well as all Amendments to this Agreement, contain all of the terms and conditions agreed upon by the parties, and when executed by all parties, supersedes any prior agreements. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall be in effect from July 1, 2001, subject to approval by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The term of this Agreement shall expire on June 30, 2012. At the mutual agreement of TENNCARE and the CONTRACTOR, this Agreement shall be renewable for an additional twelve month period.

117. Section 5.20.2.1.1 shall be amended by adding the word “incomplete” as follows:

5.20.2.1.1 For each day that a report or deliverable is late, incorrect, incomplete, or deficient, the CONTRACTOR shall be liable to TENNCARE for liquidated damages in the amount of one hundred dollars (\$100) per day per report or deliverable unless specified otherwise in this Section. Liquidated damages for late reports/deliverables shall begin on the first day the report/deliverable is late.

118. The liquidated damage chart in Section 5.20.2.2.7 shall be amended by deleting and replacing A.20 and adding new damages A.21 through A.26 as follows:

A.20	Failure to develop a person-centered plan of care for a CHOICES member that includes all of the required elements, and which has been reviewed with and signed and dated by the member or his/her representative, unless the member/representative refuses to sign which shall be documented in writing	\$500 per deficient plan of care
A.21	Failure to process a referral by or on behalf of the CONTRACTOR’s member for enrollment in the CHOICES program in accordance with specified requirements and timelines (see Section 2.9.6)	\$500 per day for each day the CONTRACTOR was delinquent in completing the referral

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<p>A.22</p>	<p>Failure to initiate disenrollment of any member who is not receiving TennCare-reimbursed long-term care services and is not expected to resume receiving long-term care services within the next thirty (30) days in accordance with 2.6.1.5.7.</p>	<p>\$1000 per occurrence plus \$1000 for each month for which the capitation payment amount must be adjusted</p>
<p>A.23</p>	<p>Failure to facilitate transitions between CHOICES Groups accordance with 2.9.6.9.1.1.5</p>	<p>\$500 per occurrence</p>
<p>A.24</p>	<p>Failure to ensure that all TennCare data containing protected health information (PHI), as defined in HIPAA, is secured through commercially reasonable methodology in compliance with HITECH, such that it is rendered unusable, unreadable and indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5 on the HHS Web site which compromises the security or privacy of TennCare enrollee protected health information ancillary Business Associate Agreement executed between the parties</p>	<p>\$500 per enrollee per occurrence, AND If the State deems credit monitoring and/or identity theft safeguards are needed to protect those TennCare enrollees whose PHI was placed at risk by CONTRACTOR's failure to comply with the terms of this Agreement, the CONTRACTOR shall be liable for all costs associated with the provision of such safeguard services.</p>

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A.25	Failure to seek express written approval from TENNCARE, including the execution of the appropriate agreements to effectuate transfer and exchange of TennCare enrollee PHI or TennCare confidential information including, but not limited to, a data use agreement, trading partner agreement, business associate agreement or qualified protective order prior to the use or disclosure of PHI to a third party for any purpose other than the purpose of this Agreement (See ancillary Business Associate Agreement executed between the parties)	\$500 per enrollee per occurrence
A.26	Failure by the CONTRACTOR to prevent the use or disclosure of TennCare enrollee data or TennCare confidential in any form via any medium with any third party beyond the boundaries and jurisdiction of the United States (See ancillary Business Associate Agreement executed between the parties)	\$1,000 per enrollee per occurrence

119. Section C of the Program Issues/Damages chart of Section 5.20.2.2.7 shall be amended by adding a new C.3 as follows and renumbering the existing C.3 through C.7 as follows including any references thereto.

C.3	Failure to have subject appropriate staff member(s) attend onsite meetings as requested and designated by TENNCARE	\$1000 per appropriate staff person per meeting as requested by TENNCARE
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120. Section 5.20.2.4 shall be amended by adding the word “CHOICES” in front of the word “HCBS”.

- 121. Section 5 shall be amended by adding new Sections 5.38 and 5.39 as follows and the existing Sections 5.38 and 5.39 shall be renumbered accordingly including any references thereto.**

5.38 Prohibition of Payments for Items or Services Outside the United States

Section 6505 of the Affordable Care Act amends section 1902(a) of the Social Security Act (the Act), and requires that a State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States (U.S.). This section of the Affordable Care Act is effective January 1, 2011, unless the Secretary determines that implementation requires State legislation, other than legislation appropriating funds, in order for the plan to comply with this provision.

For purposes of implementing this provision, section 1101(a)(2) of the Act defines the term “United States” when used in a geographical sense, to mean the “States.” Section 1101(a)(1) of the Act defines the term “State” to include the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa, when used under Title XIX.

Further, this provision prohibits payments to telemedicine providers located outside of the U.S., Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. Additionally, payments to pharmacies located outside of the U.S., Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa are not permitted.

The Centers for Medicare & Medicaid Services (CMS) will require that, in the case of providers that have provided medical assistance or covered items and/or services to Medicaid beneficiaries under the State plan or under a waiver program, and are requesting reimbursement from the State Medicaid program, such reimbursement must be provided to financial institutions or entities located within the U.S. If it is found that payments have been made to financial institutions or entities outside of the U.S., States must recover these payments and must forward any Federal match for such payments to CMS consistent with the guidelines specified in Federal regulations at 42 CFR Part 433.

Any audits of claims by CMS to assure compliance with this provision will begin no earlier than June 1, 2011 and will only review claims submitted on or after June 1, 2011 for compliance with this section.

5.39 Federal Funding Accountability and Transparency Act (FFATA)

This Agreement requires the CONTRACTOR to provide supplies and/or services that are funded in whole or in part by federal funds that are subject to FFATA. The CONTRACTOR is responsible for ensuring that all applicable requirements, including but not limited to those set forth herein, of FFATA are met and that the CONTRACTOR provides information to the State as required.

The CONTRACTOR shall comply with the following:

5.39.1 Reporting of Total Compensation of the CONTRACTOR’s Executives.

5.39.1.1 The CONTRACTOR shall report the names and total compensation of each of its five most highly compensated executives for the CONTRACTOR’s preceding completed fiscal year, if in the CONTRACTOR’s preceding fiscal year it received:

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- 5.39.1.1.1 Eighty percent (80%) or more of the CONTRACTOR's annual gross revenues from Federal procurement contracts and Federal financial assistance subject to the Transparency Act, as defined at 2 CFR 170.320 (and sub awards); and
 - 5.39.1.1.2 \$25,000,000 or more in annual gross revenues from Federal procurement contracts (and subcontracts), and Federal financial assistance subject to the Transparency Act (and sub awards); and
 - 5.39.1.1.3 The public does not have access to information about the compensation of the executives through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. 78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986. (To determine if the public has access to the compensation information, see the U.S. Security and Exchange Commission total compensation filings at <http://www.sec.gov/answers/execomp.htm>).
- Executive means officers, managing partners, or any other employees in management positions.
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- 5.39.1.2 Total compensation means the cash and noncash dollar value earned by the executive during the CONTRACTOR's preceding fiscal year and includes the following (for more information see 17 CFR 229.402(c)(2)):
 - 5.39.1.2.1 Salary and bonus.
 - 5.39.1.2.2 Awards of stock, stock options, and stock appreciation rights. Use the dollar amount recognized for financial statement reporting purposes with respect to the fiscal year in accordance with the Statement of Financial Accounting Standards No. 123 (Revised 2004) (FAS 123R), Shared Based Payments.
 - 5.39.1.2.3 Earnings for services under non-equity incentive plans. This does not include group life, health, hospitalization or medical reimbursement plans that do not discriminate in favor of executives, and are available generally to all salaried employees.
 - 5.39.1.2.4 Change in pension value. This is the change in present value of defined benefit and actuarial pension plans.
 - 5.39.1.2.5 Above-market earnings on deferred compensation which is not tax qualified.
 - 5.39.1.2.6 Other compensation, if the aggregate value of all such other compensation (e.g. severance, termination payments, value of life insurance paid on behalf of the employee, perquisites or property) for the executive exceeds \$10,000.
 - 5.39.2 The CONTRACTOR must report executive total compensation described above to the State by the end of the month during which this Contract is awarded.
 - 5.39.3 If this Agreement is amended to extend its term, the CONTRACTOR must submit an executive total compensation report to the State by the end of the month in which the amendment to this Agreement becomes effective.
 - 5.39.4 The CONTRACTOR will obtain a Data Universal Numbering System (DUNS) number and maintain its DUNS number for the term of this Agreement. More information about obtaining a

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DUNS Number can be found at: <http://fedgov.dnb.com/webform/>

- 5.39.5 The CONTRACTOR's failure to comply with the above requirements is a material breach of this Agreement for which the State may terminate this Agreement for cause. The State will not be obligated to pay any outstanding invoice received from the CONTRACTOR unless and until the CONTRACTOR is in full compliance with the above requirements.
- 122. "Timely Claims Processing", "Claims Payment Accuracy", and "HCBS Provider Network" Performance Measures in Attachment VII shall be amended by adding the word "CHOICES" in front of the word "HCBS".**
- 123. The Performance Measure regarding "Initial appointment timeliness for behavioral health services" in Attachment XII shall be deleted in its entirety.**
- 124. Exhibit D of Attachment IX shall be deleted and replaced as follows:**

ATTACHMENT IX, EXHIBIT D

Annual Plan and Quarterly Summary for the Monitoring of Behavioral Health Appointment Timeliness

I. Annual Plan for the Monitoring of Behavioral Health Appointment Timeliness

The *Annual Plan for the Monitoring of Behavioral Health Appointment Timeliness* required in Section 2.30.7.5 will be submitted to the Bureau of TennCare by December 31 of each year, with the first annual plan due for submission by December 31, 2011. This deliverable shall include, at a minimum, the following elements:

1. A plan for how the CONTRACTOR monitors and evaluates behavioral health providers for compliance with the timeliness of appointment standards that are outlined for behavioral health in Attachment III for routine MD (behavioral health) specialty care and Attachment V for Outpatient Non-MD behavioral health services.
2. The plan shall include a delineation of methodologies used for monitoring and evaluation:
 - a. The plan shall include at minimum, at least one method that incorporates either a phone survey or on-site audit.
 - b. The report shall include the frequency of surveys/audits, number of site visits, and types of providers monitored, by (MD and non-MD), and by age group (under 18 years of age and 18 years of age and over) as well as number of phone calls or number of appointments evaluated for timeliness, by type (MD/non-MD) and (under 18 years of age and 18 years of age and over) for each provider.
3. This report will also include the types of correspondence with providers regarding timeliness of appointments; number of performance reports issued to providers, number of Corrective Action Plans (CAPs) issued to providers and results of follow-up to the CAPs.
4. A summary of overall findings will include a summary of results across providers; how representative the sample of surveys/site visits are of the overall volume of services provided; analysis of data collection and identification and resolution of problems, including percentage of compliance with standards in Attachments III and V, as outlined in # 1 above.
5. Description of record keeping, including results of audits and surveys, and requests for corrective action plans submitted to providers.
6. A summary of other methods used to monitor the timeliness of behavioral health appointments.

II. Quarterly Summary for the Monitoring of Behavioral Health Appointment Timeliness

The Quarterly Summary for the Monitoring of Behavioral Health Appointment Timeliness as required in Section 2.30.7.6. will be due within thirty (30) days after completion of the quarter. This deliverable shall include, at a minimum, a summary and update of the quarterly activities and results outlined in the Annual Plan for the Monitoring of Behavioral Health Appointment Timeliness as required in Section 2.30.7.5, including strategies, results and outcomes of efforts to improve timeliness of appointments.

125. Section A.4.3.2.4.1 of Attachment XI shall be amended by deleting “one-quarter (1/4th)” and replacing it with “one-third (1/3)”.

A.4.3.2.4.1 The furthest distance a member shall be required to travel to or from a fixed route transportation stop is one-third (1/3) of a mile.

126. Sections A.12.5 and A.12.6 of Attachment XI shall be deleted and replaced as follows:

~~A.12.5 The CONTRACTOR shall provide Department of Intellectual and Developmental Disabilities (DIDD) residential and day service waiver providers the opportunity to become a NEMT provider if the provider is qualified to provide MR waiver transportation services (either as an individual transportation service or as a component of residential and/or day services) pursuant to provider qualifications applicable for such providers which shall be determined by DIDD. These providers shall only provide covered NEMT services to members receiving HCBS MR waiver services from the provider. The CONTRACTOR shall reimburse these providers for covered NEMT to TennCare covered services (see definition in Exhibit A) and shall not reimburse these providers for NEMT to services provided through a HCBS MR waiver. The CONTRACTOR shall reimburse these providers in accordance with rates paid to other NEMT providers for the provision of NEMT services.~~

A.12.6 The CONTRACTOR shall ensure that its NEMT providers are qualified to perform their duties. Except as specified in A.12.5, this includes, but is not limited to, meeting applicable federal, state or local licensure, certification, or registration requirements. Failure to comply with requirements regarding licensure requirements may result in liquidated damages as provided in Section 4.20.2 of the Agreement.

Amendment Number 25 (cont.)

127. Section A.14 of Attachment XI shall be amended by adding a new sentence as follows:

A.14 PAYMENT FOR NEMT SERVICES

A.14.1 General

In addition to requirements in the Agreement regarding payment for services, when paying for NEMT services the CONTRACTOR shall comply with the requirements in this Attachment. In addition to the requirements of this Agreement and this Attachment, the CONTRACTOR shall have a policy to address fuel price adjustments.

128. Item 13 of Exhibit A of Attachment XI shall be deleted and replaced as follows:

13. **TennCare Covered Services:** The health care services available to TennCare enrollees, as defined in TennCare rules and regulations. This includes, but is not limited to, physical health, behavioral health, pharmacy, dental services, and institutional services. TennCare covered services includes TENNderCare services. For purposes of NEMT, TennCare covered services does not include CHOICES HCBS or 1915(c) MR waiver services.

Amendment Number 25 (cont.)

All of the provisions of the original Agreement not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective July 1, 2011.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

VOLUNTEER STATE HEALTH PLAN, INC.

BY: Mark Emkes
Mark Emkes
Commissioner

BY: J. D. Hickey
J. D. Hickey
SVP President & CEO VSHP

DATE: 6/1/11

DATE: 5/26/2011

APPROVED BY:

APPROVED BY:

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

**STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY**

BY: Mark A Emkes
Mark Emkes
Commissioner
JUL 1 2011

BY: Justin P. Wilson
Justin P. Wilson
Comptroller

DATE: _____

DATE: 7/7/11

CONTRACT NOT PAID THROUGH EDISON

CONTRACT SUMMARY SHEET

RFS Number:	318.66-026	Contract Number:	FA-02-14632-24
State Agency:	Department of Finance and Administration	Division:	Bureau of TennCare
Contractor		Contract Identification Number	
VSHP (TennCare Select)		<input type="checkbox"/> V-	
		<input type="checkbox"/> C-	

Service Description

Managed Care Organization / Medically Necessary Health Care Services to the TennCare

Contract Begin Date

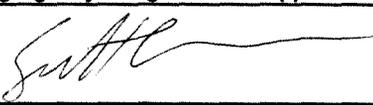
7/1/2001

Contract End Date

6/30/2011

Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66	4A2	134	11	<input type="checkbox"/> STARS		
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)	
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$ 18,599,868.48	
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$ 33,079,942.80	
2004	\$ 25,125,990.72	\$ 38,364,165.90			\$ 63,490,156.62	
2005	\$ 58,007,447.00	\$ 58,007,447.00			\$ 116,014,894.00	
2006	\$87,748,111.00	\$87,748,111.00			\$175,496,222.00	
2007	\$87,748,111.00	\$87,748,111.00			\$175,496,222.00	
2008	\$72,610,000.00	\$127,390,000.00			\$200,000,000.00	
2009	\$72,610,000.00	\$127,390,000.00			\$200,000,000.00	
2010	\$100,882,479.00	\$304,024,121.00			\$404,906,600.00	
2011	\$131,085,619.00	\$312,820,981.00			\$443,906,600.00	
Total:	\$ 658,358,818.35	\$ 1,172,631,687.55			\$1,830,990,505.90	

OCR RELEASED
 AGENCY
 TO RELEASE

CFDA#	93.778 Title XIX Dept. of Health & Human Svcs.	Check the box ONLY if the answer is YES:	
State Fiscal Contract		Is the Contractor a SUBRECIPIENT? (per OMB A-133)	<input type="checkbox"/>
Name:	Scott Pierce	Is the Contractor a Vendor? (per OMB A-133)	<input type="checkbox"/>
Address:	310 Great Circle Road	Is the Fiscal Year Funding STRICTLY LIMITED?	<input type="checkbox"/>
Phone:	Nashville, TN (615)507-6415	Is the Contractor on STARS?	<input type="checkbox"/>
Procuring Agency Budget Officer Approval Signature		Is the Contractor's FORM W-9 ATTACHED?	<input type="checkbox"/>
Scott Pierce 		Is the Contractor's Form W-9 Filed with Accounts?	<input type="checkbox"/>

COMPLETE FOR ALL AMENDMENTS (only)		
	Base Contract & Prior Amendments	This Amendment ONLY
CONTRACT END DATE:	6/30/2011	6/30/2011
FY: 2002	\$ 18,599,868.48	
FY: 2003	\$ 33,079,942.80	
FY: 2004	\$ 63,490,156.62	
FY: 2005	\$116,014,894.00	
FY: 2006	\$175,496,222.00	
FY: 2007	\$175,151,878.00	
FY: 2008	\$200,000,000.00	
FY: 2009	\$200,000,000.00	
FY: 2010	\$404,906,600.00	
FY: 2011	\$443,906,600.00	
Total:	\$1,830,990,505.90	

Funding Certification

Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.

RECEIVED
 JAN 7 2011
 MANAGEMENT SERVICES
 RECEIVED

AMENDMENT NUMBER 24

**AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.**

CONTRACT NUMBER: FA-02-14632-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as specified below.

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. Section 1 shall be amended by deleting the following definitions: “Clinically Related Group 1: Severely and/or Persistently Mentally Ill (SPMI)”, “Clinically Related Group 2: Persons with Severe Mental Illness (SMI)”, “Clinically Related Group 3: Persons who are Formerly Severely Impaired”, “Clinically Related Group 4: Persons with Mild or Moderate Mental Disorders”, “Clinically Related Group 5: Persons who are not in clinically related groups 1-4 as a result of their diagnosis”, “CRG (Clinically Related Group)”, “Seriously Emotionally Disturbed (SED)”, “Severely and/or Persistently Mentally Ill (SPMI)” and “Target Population Group (TPG)”.

2. Section 1 shall be amended by adding a new definition for “Priority Enrollee” as follows:

Priority Enrollee: An enrollee that has been identified by TENNCARE as vulnerable due to certain mental health diagnoses.

3. Section 2.7.1.2 and 2.7.1.3 shall be amended by adding a new sentence to the end of the existing language as follows:

2.7.1.2 The CONTRACTOR shall review and approve or disapprove claims for emergency services based on the definition of emergency medical condition specified in Section 1 of this Agreement. The CONTRACTOR shall base coverage decisions for emergency services on the severity of the symptoms at the time of presentation and shall cover emergency services where the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. The CONTRACTOR shall not impose restrictions on coverage of emergency services more restrictive than those permitted by the prudent layperson standard. The CONTRACTOR shall have policies that address emergency and non-emergency use of services provided in an outpatient emergency setting.

2.7.1.3 The CONTRACTOR shall provide coverage for inpatient and outpatient emergency services, furnished by a qualified provider, regardless of whether the member obtains the services from a contract provider, that are needed to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard. These services shall be provided

Amendment Number 24 (cont.)

without prior authorization in accordance with 42 CFR 438.114. The CONTRACTOR shall pay for any emergency screening examination services conducted to determine whether an emergency medical condition exists and for all emergency services that are medically necessary until the member is stabilized. However, the CONTRACTOR shall have policies to determine when non-emergency services are provided in an outpatient emergency setting.

4. Section 2.7.2.8.1.5 shall be deleted and replaced as follows:

2.7.2.8.1.5 Prior to admission to a psychiatric inpatient hospital on an involuntary basis, the CONTRACTOR shall ensure that Tennessee's statutory requirement for a crisis team consultation is completed for all members evaluated by a licensed physician or psychologist as described in TennCare policy. In addition, the CONTRACTOR shall ensure that Tennessee's statutory requirement for a face-to-face evaluation by a mandatory pre-screening agent (MPA), is conducted to assess eligibility for emergency involuntary admission to an RMHI (Regional Mental Health Institute) and determine whether all available less drastic alternatives services and supports are unsuitable.

5. Sections 2.7.2.9 through 2.7.2.9.7 shall be deleted in their entirety and the remaining Section 2.7.2 shall be renumbered accordingly including any references thereto.

6. Section 2.7.6.2.10.1, 2.7.6.2.10.1.1, and 2.7.6.2.10.2 shall be deleted and replaced as follows:

2.7.6.2.10.1 Outreach events shall number a minimum of five (5) per region, per quarter.

2.7.6.2.10.1.1. At least three (3) of the minimum quarterly outreach activities shall be conducted in urban areas, and two (2) shall be conducted in rural/suburban areas. Results of the CONTRACTOR's or State's CMS 416 and HEDIS reports, as well as county demographics, shall be utilized in determining counties for targeted activities and in developing strategies for TennCare enrollees who are at risk of DCS custody or have special healthcare needs.

2.7.6.2.10.2 The CONTRACTOR shall contact a minimum of fifteen (15) state agencies or community-based organizations per quarter, to either educate them on services available through the MCOs or to develop outreach and educational initiatives. All of the agencies engaged shall be those who serve TennCare enrollees who are at risk of DCS custody or have special healthcare needs.

7. Section 2.7.8.1 shall be deleted and replaced as follows:

2.7.8.1 The CONTRACTOR shall cover abortions, sterilizations, and hysterectomies (ASH) pursuant to applicable federal and state law. The CONTRACTOR shall ensure that when coverage requires the completion of a specific form, the form is properly completed as described in the instructions with the original form maintained in the member's medical records and a copy submitted to the CONTRACTOR for retention in the event of audit. In the event of a TennCare audit the CONTRACTOR will provide additional supporting documentation to ascertain compliance with federal and state regulations. Such documentation may include admission history and physical, pre and post procedure notes, discharge summary, court records or orders, or other documentation utilized to authorize ASH procedures utilized to authorize ASH procedures, specific to the type of procedure performed.

8. Section 2.8.1 shall be amended by deleting and replacing Section 2.8.1.2, adding a new Section 2.8.1.3 and renumbering the existing Sections accordingly including any references thereto.

2.8.1.2 Each DM program shall utilize evidence-based clinical practice guidelines (hereafter referred to as the guidelines) that have been formally adopted by the CONTRACTOR's Quality Management/Quality Improvement (QM/QI) committee or other clinical committee as a clinical basis for development of program content and plan of care.

2.8.1.3 For the conditions listed in Sections 2.8.1.1.1 through 2.8.1.1.7, the DM Health Risk Assessment shall include screening for mental health and substance abuse. For conditions listed in Sections 2.8.1.1.8 through 2.8.1.1.10, the DM Health Risk Assessment shall include an evaluation for co-occurring disorders.

9. Section 2.8.3 shall be amended by renumbering the existing text as 2.8.3.1 and adding new text in a new Section 2.8.3.2 as follows:

2.8.3 Stratification

2.8.3.1 As part of the DM programs, the CONTRACTOR shall classify eligible members into stratification levels according to condition severity or other clinical or member-provided information which, for members enrolled in the CHOICES program shall also include stratification by the type of setting in which long-term care services are delivered, i.e., nursing facility, community-based residential alternative, or home-based. The DM programs shall tailor the program content and education activities for each stratification level. For CHOICES members, this shall include targeted interventions based on the setting in which the member resides.

2.8.3.2 As a part of the Maternity DM program, the contractor shall classify all pregnant women who use tobacco in the high risk category and refer those members, who consent, to the Tennessee Tobacco Quitline using the Quitline referral form (or a TENNCARE approved smoking cessation program).

10. Section 2.8.4 shall be deleted and replaced as follows:

2.8.4 Program Content

Each DM program shall include the development of program content plans, as described in NCQA Disease Management Standards as treatment plans, to serve as the outline for all of the activities and interventions in the program focusing on patient empowerment strategies to support the provider-patient relationship. At a minimum the activities and interventions shall address condition monitoring, patient adherence to the program, consideration of other co-morbidities, and condition-related lifestyle issues. For CHOICES members, appropriate elements of the program content plan shall be individualized and integrated into the member's plan of care to facilitate better management of the member's condition.

Amendment Number 24 (cont.)

11. Section 2.8.7.2 through 2.8.7.2.6 shall be deleted and replaced with new Sections 2.8.7.2, and 2.8.7.3 through 2.8.7.3.6 as described below. The current Section 2.8.7.3 shall be renumbered as 2.8.7.4.

2.8.7.2 The CONTRACTOR shall report the passive participation rates (as defined by NCQA) and the number of individuals participating in each level of each of the DM programs.

2.8.7.3 The CONTRACTOR shall establish measurable benchmarks and goals for each DM program and shall evaluate the programs using these benchmarks and goals. The calculations for the benchmarks and goals should include non-CHOICES members only. These benchmarks and goals shall include:

2.8.7.3.1 The rate of emergency department utilization and inpatient hospitalization;

2.8.7.3.2 Neonatal Intensive Care Unit (NICU) data associated with members enrolled in the maternity care management program;

2.8.7.3.3 Appropriate HEDIS measures;

2.8.7.3.4 Member adherence to treatment plans;

2.8.7.3.5 Provider adherence to the guidelines; and

2.8.7.3.6 DM specific member satisfaction survey results.

12. Sections 2.9.4.2.7.1 and 2.9.4.2.7.2 shall be deleted and replaced as follows and the remaining Section 2.9.4.2.7 shall be renumbered accordingly including any references thereto.

2.9.4.2.7.1 Priority Enrollees;

13. Section 2.9.5.1.5 shall be deleted and replaced as follows:

2.9.5.1.5 Program Evaluation (Satisfaction and Effectiveness) which shall include the following:

2.9.5.1.5.1 The rate of in-patient admissions and re-admissions of CM members;

2.9.5.1.5.2 The rate of ED utilization by CM members; and

2.9.5.1.5.3 Percent of member satisfaction specific to CM.

14. Section 2.9.6.2.4 shall be amended by deleting and replacing Section 2.9.6.2.4.2, deleting Sections 2.9.6.2.4.3 and 2.9.6.2.4.4 and renumbering the remaining Section 2.9.6.2.4 as appropriate including all references thereto.

2.9.6.2.4.2 For members in CHOICES Group 1 who are receiving services in a nursing facility at the time of enrollment in, the CONTRACTOR shall immediately authorize NF services in accordance with the level of nursing facility services or reimbursement approved by TENNCARE, and as of the effective date of CHOICES enrollment. The

Amendment Number 24 (cont.)

CONTRACTOR shall, within thirty (30) calendar days of notice of the member's enrollment in CHOICES, conduct a face-to-face visit with the member and perform any additional needs assessment deemed necessary by the CONTRACTOR (see Section 2.9.6.5.1). The care coordinator shall review the plan of care developed by the nursing facility and may supplement the plan of care as necessary and appropriate (see Section 2.9.6.6.1).

15. Section 2.9.6.2.5.2 and 2.9.6.2.5.3 shall be deleted and replaced as follows:

2.9.6.2.5.2 For members in CHOICES Group 2 who upon CHOICES enrollment are receiving services in a community-based residential alternative setting, within ten (10) business days of notice of the member's enrollment in CHOICES the care coordinator shall conduct a face-to-face visit with the member, perform a comprehensive needs assessment (see Section 2.9.6.5), develop a plan of care (see Section 2.9.6.6), and authorize and initiate additional HCBS specified in the plan of care (i.e., assistive technology), except in the case of members enrolled on the basis of Immediate Eligibility. If a member residing in a community-based residential alternative setting is enrolled on the basis of Immediate Eligibility, the CONTRACTOR shall, upon notice that the State has determined that the member meets categorical and financial eligibility for TennCare CHOICES, immediately authorize community-based residential services and shall authorize and initiate additional HCBS specified in the member's plan of care (i.e., assistive technology) within five (5) days of notice; authorization for community-based residential alternative services shall be retroactive to the member's effective date of CHOICES enrollment.

2.9.6.2.5.3 The care coordinator shall, for all other CHOICES members in Groups 2 and 3 not specified in 2.9.6.2.5.1 – 2.9.6.2.5.2 above, within ten (10) business days of notice of the member's enrollment in CHOICES, conduct a face-to-face visit with the member, perform a comprehensive needs assessment (see Section 2.9.6.5), develop a plan of care (see Section 2.9.6.6), and authorize and initiate HCBS, except in the case of members enrolled on the basis of Immediate Eligibility in which case only the limited package of HCBS shall be authorized and initiated. Members enrolled on the basis of Immediate Eligibility shall have access only to a limited package of HCBS (see Section 2.6.1.5.3) pending determination of categorical and financial eligibility for TennCare CHOICES; however all needed services shall be listed in the plan of care, and the CONTRACTOR shall immediately revise the service authorizations as necessary upon notice that the State has determined that the member meets categorical and financial eligibility for TennCare CHOICES and initiate services within ten (10) business days of notice.

16. The first paragraph numbered Section 2.9.6.3.17 shall be deleted and replaced as follows:

2.9.6.3.17 For all newly enrolled CHOICES Group 1 members, the CONTRACTOR shall immediately authorize NF services in accordance with the level of nursing facility services or reimbursement approved by TENNCARE, and as of the effective date of CHOICES enrollment. To the extent that applicable activities specified in Sections 2.9.6.3.8, 2.9.6.3.8.1 and 2.9.6.3.9 were not completed by the CONTRACTOR during the member's CHOICES enrollment process, the member's Care Coordinator shall within thirty (30) calendar days of notice of the member's enrollment in CHOICES Group 1, conduct a face-to-face visit, perform any additional needs assessment deemed necessary, and may supplement the plan of care as necessary and appropriate.

For the CONTRACTOR's current members enrolled into CHOICES Group 2, the member's Care Coordinator shall within ten (10) business days of notice of the member's enrollment in CHOICES Group 2, authorize and initiate HCBS. To the extent that applicable activities specified in Sections 2.9.6.3.8, 2.9.6.3.8.2 and 2.9.6.3.9 were not completed by the CONTRACTOR during the member's CHOICES enrollment process, the member's Care Coordinator shall also within ten (10) business days of notice of the member's enrollment in CHOICES Group 2, conduct a face-to-face visit, perform a comprehensive needs assessment, and develop a plan of care.

17. Section 2.9.8.4 shall be deleted and replaced as follows:

2.9.8.4 Referrals to Behavioral Health Providers

The CONTRACTOR shall ensure through screening that members with a need for behavioral health services, particularly priority enrollees are appropriately referred to behavioral health providers. The CONTRACTOR shall develop provider education and training materials to ensure that physical health and long-term care providers know when and how to refer members who need specialty behavioral health services. This shall include education about behavioral health services, including the recovery process and resilience for children. The CONTRACTOR shall develop a referral process to be used by its providers, including what information must be exchanged and when to share this information, as well as notification to the member's care coordinator.

18. Section 2.11.7.2 shall be deleted and replaced as follows:

2.11.7.2 Community Mental Health Agencies (CMHAs)

The CONTRACTOR is encouraged to contract with CMHAs and other behavioral health safety net providers in the CONTRACTOR's service area to the extent possible and practical. Where CMHAs are not utilized, the CONTRACTOR shall demonstrate that both adequate capacity and an appropriate range of services for all populations, but in particular priority enrollees, exist to serve the expected enrollment in the CONTRACTOR's service area without contracting with CMHAs.

19. Section 2.12.9.60 shall be deleted and replaced as follows:

2.12.9.60 Require the provider to comply and submit to the CONTRACTOR disclosure of information in accordance with the requirements, including timeframes, specified in 42 CFR Part 455, Subpart B and at anytime upon request;

20. Section 2.12.15 shall be deleted in its entirety and the remaining Sections in 2.12 shall be renumbered accordingly including any references thereto.

21. The renumbered Section 2.12.15 shall be deleted and replaced as follows:

2.12.15 The CONTRACTOR shall comply with the Annual Coverage Assessment Act, (T.C.A. 71-5-1003 *et seq.*, 71-5-1005 *et seq.*).

Amendment Number 24 (cont.)

- 2.12.15.1 The CONTRACTOR shall be prohibited from implementing across the board rate reductions to covered or excluded contract hospitals or physicians either by category or type of provider. These requirements shall also apply to services or settings of care that are ancillary to a covered or excluded hospital, or physician's primary license if the physician or covered or excluded hospital, including a wholly owned subsidiary or controlled affiliate of a covered or excluded hospital or hospital system, holds more than fifty percent (50%) controlling interest in such ancillary services or settings of care, but shall not apply to any other ancillary services or settings of care. For purposes of this Section, covered or excluded contract hospitals or physicians shall be those as defined by the Annual Coverage Assessment Act.
 - 2.12.15.2 The CONTRACTOR shall notice providers regarding across the board rate reductions and shall include language in the notice that describes those providers to be excluded from the across the board rate reduction in accordance with the Annual Coverage Assessment Act. The provider exclusion language shall be conspicuously placed on the front page of the notice and will advise providers who believe they meet the exclusion criteria specified in the Act of the process for demonstrating such to the MCO.
 - 2.12.15.3 For purposes of this requirement, services or settings of care that are "ancillary" shall mean, but not be limited to, ambulatory surgical facilities, outpatient treatment clinics or imaging centers, dialysis centers, home health and related services, home infusion therapy services, outpatient rehabilitation or skilled nursing services. Further, for purposes of this requirement, "physician" includes a physician licensed under title 63, chapter 6 and chapter 9 and a group practice of physicians that hold a contract with the CONTRACTOR.
- 22. Section 2.15.7.6 shall be amended by deleting the word “monthly” and replacing it with the word “quarterly”.**
- 2.15.7.6 As specified in Section 2.30.11.6, the CONTRACTOR shall submit quarterly reports to TENNCARE regarding all critical incidents.
- 23. Sections 2.18.7.4 and 2.18.7.5 shall be deleted and replaced as follows:**
- 2.18.7.4 The CONTRACTOR shall conduct an annual survey to assess provider satisfaction, including satisfaction with provider enrollment, provider communication, provider education, provider complaints, claims processing, claims reimbursement, care coordination, and utilization management processes, including medical reviews. The CONTRACTOR shall include questions specified by TENNCARE. The CONTRACTOR shall submit an annual report on the survey to TENNCARE as required in Section 2.30.12.4. The CONTRACTOR shall take action to address opportunities for improvement identified through the survey and provide an update on actions taken in the previous year to improve provider satisfaction. The survey shall be structured so that behavioral health provider satisfaction results and physical health provider satisfaction results can be separately stratified.
 - 2.18.7.5 The CONTRACTOR shall conduct an annual satisfaction survey of CHOICES long-term care providers that shall include any questions specified in the survey tool provided by TENNCARE. The CONTRACTOR shall submit an annual report on the survey to TENNCARE as required in Section 2.30.12.4. The CONTRACTOR shall take action to address opportunities for improvement identified through the survey and provide an update on actions taken in the previous year to improve provider satisfaction. .

24. Section 2.20 shall be deleted and replaced as follows:

2.20 FRAUD AND ABUSE

2.20.1 General

- 2.20.1.1 The Tennessee Bureau of Investigation, Medicaid Fraud Control Unit (TBI MFCU) is the state agency responsible for the investigation of provider fraud and abuse in the TennCare program.
- 2.20.1.2 The Office of Inspector General (OIG) has the primary responsibility to investigate TennCare enrollee fraud and abuse.
- 2.20.1.3 The CONTRACTOR shall have surveillance and utilization control programs and procedures (42 CFR 456.3, 456.4, 456.23) to safeguard the Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments. The CONTRACTOR shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities.
- 2.20.1.4 The CONTRACTOR shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the CONTRACTOR in preventing and detecting potential fraud and abuse activities.
- 2.20.1.5 The CONTRACTOR shall comply with all federal and state requirements regarding fraud and abuse, including but not limited to Sections 1128, 1156, and 1902(a)(68) of the Social Security Act.

2.20.2 Reporting and Investigating Suspected Fraud and Abuse

- 2.20.2.1 The CONTRACTOR shall cooperate with all appropriate state and federal agencies, including TBI MFCU and/or OIG, in investigating fraud and abuse. In addition, the CONTRACTOR shall fully comply with the TCA 71-5-2601 and 71-5-2603 in performance of its obligations under this Agreement. The CONTRACTOR shall report all confirmed or suspected fraud and abuse to TENNCARE and the appropriate agency as follows:
 - 2.20.2.1.1 Suspected fraud and abuse in the administration of the program shall be reported to TBI MFCU and/or OIG;
 - 2.20.2.2 The CONTRACTOR shall have methods for identification, investigation, and referral of suspected fraud cases (42 CFR 455.13, 455.14, 455.21). All confirmed or suspected provider fraud and abuse shall immediately be reported to TBI MFCU and TennCare Office of Program Integrity; and
 - 2.20.2.2.1 All confirmed or suspected enrollee fraud and abuse shall be reported immediately to OIG;
 - 2.20.2.3 The CONTRACTOR shall use the Fraud Reporting Forms in Attachment VI, or such other form as may be deemed satisfactory by the agency to whom the report is to be made under the terms of this Agreement.

Amendment Number 24 (cont.)

- 2.20.2.4 Pursuant to TCA 71-5-2603(c) the CONTRACTOR shall be subject to a civil penalty, to be imposed by the OIG, for willful failure to report fraud and abuse by recipients, enrollees, applicants, or providers to TENNCARE and OIG or TBI MFCU, as appropriate.
- 2.20.2.5 The CONTRACTOR shall promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud and abuse. Unless prior written approval is obtained from the agency to whom the incident was reported, or to another agency designated by the agency that received the report, after reporting fraud or suspected fraud and/or suspected abuse and/or confirmed abuse, the CONTRACTOR shall not take any of the following actions as they specifically relate to TennCare claims:
 - 2.20.2.5.1 Contact the subject of the investigation about any matters related to the investigation;
 - 2.20.2.5.2 Enter into or attempt to negotiate any settlement or agreement regarding the incident; or
 - 2.20.2.5.3 Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.
- 2.20.2.6 The CONTRACTOR shall promptly provide the results of its preliminary investigation to the agency to whom the incident was reported, or to another agency designated by the agency that received the report.
- 2.20.2.7 The CONTRACTOR shall cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation shall include providing, upon request, information, access to records, and access to interview CONTRACTOR employees and consultants, including but not limited to those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation.
- 2.20.2.8 The State shall not transfer its law enforcement functions to the CONTRACTOR.
- 2.20.2.9 The CONTRACTOR and providers, whether contract or non-contract, shall, upon request and as required by this Agreement or state and/or federal law, make available to the TBI MFCU/OIG any and all administrative, financial and medical records relating to the delivery of items or services for which TennCare monies are expended. In addition, the TBI MFCU/OIG shall, as required by this Agreement or state and/or federal law, be allowed access to the place of business and to all TennCare records of any contractor or provider, whether contract or non-contract, during normal business hours, except under special circumstances when after hour admission shall be allowed. Special circumstances shall be determined by the TBI MFCU/OIG.
- 2.20.2.10 The CONTRACTOR shall include in any of its provider agreements a provision requiring, as a condition of receiving any amount of TennCare payment, that the provider comply with this Section, Section 2.20 of this Agreement.
- 2.20.2.11 The CONTRACTOR shall notify TENNCARE when the CONTRACTOR denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.

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- 2.20.2.12 Except as described in Section 2.11.7.2 of this Agreement, nothing herein shall require the CONTRACTOR to ensure non-contract providers are compliant with TENNCARE contracts or state and/or federal law.

2.20.3 Compliance Plan

- 2.20.3.1 The CONTRACTOR shall have a written fraud and abuse compliance plan. A paper and electronic copy of the plan shall be provided to the TennCare Program Integrity Unit within ninety (90) calendar days of Agreement execution and annually thereafter. TENNCARE shall provide notice of approval, denial, or modification to the CONTRACTOR within thirty (30) calendar days of receipt. The CONTRACTOR shall make any requested updates or modifications available for review to TENNCARE as requested by TENNCARE and/or the TennCare Program Integrity Unit within thirty (30) calendar days of a request.
- 2.20.3.2 The CONTRACTOR's fraud and abuse compliance plan shall:
 - 2.20.3.2.1 Require that the reporting of suspected and/or confirmed fraud and abuse be done as required by this Agreement;
 - 2.20.3.2.2 Outline activities proposed for the next reporting year regarding employee education of federal and state laws and regulations related to Medicaid Program Integrity against Fraud/Abuse/Waste to ensure that all of its officers, directors, managers and employees know and understand the provisions of the CONTRACTOR's fraud and abuse compliance plan;
 - 2.20.3.2.3 Outline activities proposed for the next reporting year regarding provider education of federal and state laws and regulations related to Medicaid Program Integrity against Fraud/Abuse/Waste and on identifying and educating targeted providers with patterns of incorrect billing practices and/or overpayments;
 - 2.20.3.2.4 Outline unique policy and procedures, and specific instruments designed to identify, investigate, and report fraud and abuse activities under the CHOICES' program.
 - 2.20.3.2.5 Contain procedures designed to prevent and detect abuse and fraud in the administration and delivery of services under this Agreement; and
 - 2.20.3.2.6 Include a description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse, such as:
 - 2.20.3.2.6.1 A list of automated pre-payment claims edits;
 - 2.20.3.2.6.2 A list of automated post-payment claims edits;
 - 2.20.3.2.6.3 A list of desk audits on post-processing review of claims;
 - 2.20.3.2.6.4 A list of reports of provider profiling and credentialing used to aid program and payment integrity reviews;
 - 2.20.3.2.6.5 A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services.

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- 2.20.3.2.6.6 A list of provisions in the subcontractor and provider agreements that ensure the integrity of provider credentials; and
- 2.20.3.2.6.7 A list of references in provider and member material regarding fraud and abuse referrals.
- 2.20.3.2.7 A list of provisions for the confidential reporting of plan violations to the designated person;
- 2.20.3.2.8 A list of provisions for the investigation and follow-up of any suspected or confirmed fraud and abuse, even if already reported, and/or compliance plan reports;
- 2.20.3.2.9 Ensure that the identities of individuals reporting violations of the CONTRACTOR's MCO are protected and that there is no retaliation against such persons;
- 2.20.3.2.10 Contain specific and detailed internal procedures for officers, directors, managers and employees for detecting, reporting, and investigating fraud and abuse compliance plan violations;
- 2.20.3.2.11 Require any confirmed or suspected provider fraud and abuse under state or federal law be reported to TBI MFCU as well as TennCare Office of Program Integrity and that enrollee fraud and abuse be reported to the OIG; and
- 2.20.3.2.12 Ensure that no individual who reports MCO violations or suspected fraud and abuse is retaliated against.
- 2.20.3.3 The CONTRACTOR shall have provisions regarding compliance with the applicable requirements of the Model Compliance Plan for Medicaid MCOs or Medicare+Choice Organizations/Medicare Advantage plans issued by the DHHS OIG.
- 2.20.3.4 The CONTRACTOR shall provide a list of procedures regarding implementation of TennCare policy on disclosure and adverse action reporting (<http://www.tn.gov/tenncare/forms/fa10-001.pdf>).
- 2.20.3.5 The CONTRACTOR shall have provisions in its Compliance plan regarding the reporting of fraud and abuse activities as required in Section 2.30.13, Reporting Requirements.
- 2.20.3.6 The CONTRACTOR shall have provisions in its Compliance Plan regarding conducting monthly comparison of their provider files, including atypical providers, against either the Medicare Exclusion Database (the MED) or the HHS-OIG List of Excluded Individuals/Entities (LEIE) and provide a report of the result of comparison to TENNCARE each month. The CONTRACTOR must establish an electronic database to capture identifiable information on the owners, agents and managing employees listed on providers' Disclosure forms.
- 2.20.3.7 The CONTRACTOR shall have provisions in its Compliance Plan regarding performing a monthly check for exclusions of their owners, agents and managing employees. The CONTRACTOR shall establish an electronic database to capture identifiable information on its owners, agents and managing employees and perform monthly exclusion checking. The CONTRACTOR shall provide the State Agency with such database and a monthly report of the exclusion check.

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2.20.3.8 The CONTRACTOR shall have provisions in its Compliance Plan regarding prompt terminations of inactive providers due to inactivity in the past 12 months.

25. Section 2.21.4.1.3 through 2.21.4.1.3.3 shall be deleted and replaced as follows:

2.21.4.1.3 If the probable existence of TPL has been established at the time the claim is filed, the CONTRACTOR may reject the claim and return it to the provider for a determination of the amount of any TPL, unless the claim is for services described in TennCare policy, including the State Medicaid Manual, Section 3904.4.

26. The opening paragraph in Section 2.21.9 through Section 2.21.9.5.5 shall be deleted and replaced as follows:

2.21.9 Ownership and Financial Disclosure

2.21.9.1 The CONTRACTOR shall disclose, to TENNCARE, the Comptroller General of the United States or CMS, full and complete information regarding ownership, financial transactions and persons convicted of criminal activity related to Medicare, Medicaid, or the federal Title XX programs in the time and manner set forth in accordance with federal and state requirements, including 42 CFR §55.104 and Public Chapter 379 of the Acts of 1999.

2.21.9.2 The CONTRACTOR and its subcontractors shall collect the disclosure of health care-related criminal conviction information as required by 42 CFR§ 455.106 and establish policies and procedures to ensure that applicable criminal convictions are reported timely to the State. The CONTRACTOR shall screen their employees and contractors initially and on an ongoing monthly basis to determine whether any of them has been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded. The results of said screenings shall be provided to TENNCARE on a monthly basis. The word “contractors” in this section shall refer to all individuals listed on the disclosure form including providers and non-providers such as board members, owners, agents, managing employees, etc.

2.21.9.3 The CONTRACTOR and its subcontractors shall agree to disclose business transaction information upon request and as otherwise specified in federal and state regulations.

2.21.9.4 Disclosures shall be made in accordance with the requirements in Section 2.30.15.2.2. The following information shall be disclosed:

2.21.9.4.1 The name and address of each person with an ownership or control interest in the disclosing entity or in any provider, subcontractor or fiscal agent in which the disclosing entity has direct or indirect ownership of five percent (5%) or more and whether any of the persons named pursuant to this requirement is related to another as spouse, parent, child, or sibling. This disclosure shall include the name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest;

2.21.9.4.2 The identity of any provider or subcontractor with whom the CONTRACTOR has had significant business transactions, defined as those totaling more than twenty-five thousand dollars (\$25,000) during the twelve (12) month period ending on the date of the disclosure,

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and any significant business transactions between the CONTRACTOR, any wholly owned supplier, or between the CONTRACTOR and any provider or subcontractor, during the five (5) year period ending on the date of the disclosure;

- 2.21.9.4.3 The identity of any person who has an ownership or control interest in the CONTRACTOR, or is an agent or managing employee of the CONTRACTOR and who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the federal Title XX services program since the inception of those programs;
- 2.21.9.4.4 Disclosure from officials in legislative and executive branches of government as to possible conflicts of interest;
- 2.21.9.4.5 If the CONTRACTOR is not a federally qualified HMO, the CONTRACTOR shall disclose certain transactions with parties in interest to TENNCARE. Transactions shall be reported according to the following guidelines:
 - 2.21.9.4.5.1 The CONTRACTOR shall disclose the following transactions:
 - 2.21.9.4.5.1.1 Any sale, exchange or lease of any property between the HMO and a party in interest;
 - 2.21.9.4.5.1.2 Any lending of money or other extension of credit between the HMO and a party in interest; and
 - 2.21.9.4.5.1.3 Any furnishing for consideration of goods, services (including management services) or facilities between the HMO and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.
 - 2.21.9.4.5.2 The information which shall be disclosed in the transactions includes:
 - 2.21.9.4.5.2.1 The name of the party in interest for each transaction;
 - 2.21.9.4.5.2.2 A description of each transaction and the quantity or units involved;
 - 2.21.9.4.5.2.3 The accrued dollar value of each transaction during the fiscal year; and
 - 2.21.9.4.5.2.4 Justification of the reasonableness of each transaction.
 - 2.21.9.4.5.3 If the Agreement is being renewed or extended, the CONTRACTOR shall disclose information on business transactions which occurred during the prior contract period. If the Agreement is an initial Agreement with TENNCARE, but the CONTRACTOR has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period shall be disclosed. The business transactions which shall be reported are not limited to transactions related to serving the Medicaid/TennCare enrollment. All of the CONTRACTOR's business transactions shall be reported.
 - 2.21.9.4.5.4 A party in interest is:
 - 2.21.9.4.5.4.1 Any director, officer, partner, or employee responsible for management or administration of an HMO and HIO; any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of the HMO; any person who is the beneficial

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owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than five percent (5%) of the HMO; or, in the case of an HMO organized as a nonprofit corporation, an incorporator or member of such corporation under applicable state corporation law;

- 2.21.9.4.5.4.2 Any organization in which a person described in subsection 1 is director, officer or partner; has directly or indirectly a beneficial interest of more than five percent (5%) of the equity of the HMO; or has a mortgage, deed of trust, note, or other interest valuing more than five percent (5%) of the assets of the HMO;
- 2.21.9.4.5.4.3 Any person directly or indirectly controlling, controlled by, or under common control with an HMO; or
- 2.21.9.4.5.4.4 Any spouse, child, or parent of an individual described in Sections 2.21.9.5.4.1, 2.21.9.5.4.2, or 2.21.9.5.4.3.
- 2.21.9.4.5.5 TENNCARE and/or the Secretary of Health and Human Services may request information to be in the form of a consolidated financial statement.

27. Section 2.24.2.1 shall be deleted and replaced as follows:

- 2.24.2.1 The CONTRACTOR's behavioral health advisory committee shall be comprised of at least fifty-one percent (51%) consumer and family representatives, of which the majority shall include individuals and/or families of those who may meet the clinical criteria of a priority enrollee.

28. Sections 2.28.2 and 2.28.7 shall be deleted and replaced as follows:

- 2.28.2 In order to demonstrate compliance with federal and state regulations of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), the Church Amendments (42 U.S.C. 300a-7), Section 245 of the Public Health Service Act (42 U.S.C. 238n.), and the Weldon Amendment (Consolidated Appropriations Act 2008, Public Law 110-161, Div. G, Sec. 508 (d), 121 Stat. 1844, 2209), the CONTRACTOR shall designate a staff person to be responsible for non-discrimination compliance as required in Section 2.29.1. This person shall develop a CONTRACTOR non-discrimination compliance training plan. This person shall provide instruction to all CONTRACTOR staff, providers and direct service subcontractors regarding the CONTRACTOR's non-discrimination policies and procedures and all applicable non-discrimination compliance requirements of the plan. The CONTRACTOR shall be able to show documented proof of such instruction.

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2.28.7 The CONTRACTOR shall track and investigate all complaints alleging discrimination filed by employees, enrollees, providers and subcontractors related to the provision of and/or access to TennCare covered services provided by the CONTRACTOR. The CONTRACTOR shall track and investigate all complaints alleging discrimination filed by employees (when the complaint is related to the TennCare program), enrollees, providers and subcontractors in which discrimination is alleged in the CONTRACTOR's TennCare MCO. The CONTRACTOR shall track, at a minimum, the following elements: identity of the party filing the complaint; the complainant's relationship to the CONTRACTOR; the circumstances of the complaint; date complaint filed; CONTRACTOR's resolution, date of resolution; and name of CONTRACTOR staff person responsible for adjudication of the complaint.

29. Section 2.30.4.2 shall be deleted and replaced as follows:

2.30.4.2 The CONTRACTOR shall submit a quarterly *Post-Discharge Services Report* that provides information on Post-Discharge services appointments. The minimum data elements required are identified in Attachment IX, Exhibit B.

30. Section 2.30.4.3 and Sections 2.30.4.5 through 2.30.4.8 shall be deleted in their entirety and the remaining Sections of 2.30.4 shall be renumbered accordingly including any references thereto.

31. Sections 2.30.5.1 and 2.30.5.2 shall be deleted and replaced as follows:

2.30.5.1 The CONTRACTOR shall submit a quarterly Disease Management Update Report that includes, for each disease management program (see Section 2.8), a brief narrative description of the program, the total number of members in the program, the total number of members enrolled and disenrolled during the quarter, and a description of the specific provider and member interventions performed during the quarter. The report shall include the number of pregnant women identified as tobacco users who were actively referred to the Tennessee Tobacco Quitline and their referral status and other interventions around smoking cessation performed during the quarter. The report shall include a chart and narrative for CHOICES members in DM to include the total number of members receiving DM interventions, by DM condition; the total number of CHOICES members starting and terminating DM interventions during the quarter, a description of any specific provider and member interventions that were new during the quarter, the number of member and provider activities/interventions, and a written analysis of data provided.

2.30.5.2 The CONTRACTOR shall submit on July 1 an annual *Disease Management Report* that includes, for each disease management programs, a narrative description of the eligibility criteria and the method used to identify and enroll eligible members, the passive participation rate as defined by NCQA (the percentage of identified eligible members who have received an intervention divided by the total population who meet the criteria for eligibility), the total number of active members having one or more of the diagnosis codes (ICD-9 Codes) relating to each of the disease management programs, a description of stratification levels for each DM program including member criteria and associated interventions, a discussion of barriers and challenges to include resources, program structure, member involvement and provider participation, a summary of member satisfaction with the DM program, a written analysis of the data presented, a description of proposed changes to program, and information on the programs' activities, benchmarks and goals as described in Section 2.8.7 including the number of pregnant women identified as tobacco users who were actively referred to the

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Tennessee Tobacco Quitline and their referral status. The report shall include a separate chart(s) and narrative for CHOICES members in DM to include a narrative description of the eligibility criteria and the method used to identify and enroll eligible CHOICES members, a description of stratification levels based on the setting in which the member resides; total number of CHOICES members identified as having a DM condition, total number of members receiving DM activities/interventions, and the number of CHOICES members by level of stratification; a discussion of barriers and challenges to include resources, program structure, member involvement, and provider participation along with a description of proposed changes.

32. Section 2.30.7.8 shall be deleted in its entirety.

33. Section 2.30.12.4 shall be deleted and replaced as follows:

2.30.12.4 The CONTRACTOR shall submit an annual *Provider Satisfaction Survey Report* that encompasses behavioral and physical health as well as a *CHOICES Provider Satisfaction Survey Report* that addresses results for CHOICES long-term care providers. The report shall summarize the provider survey methods and findings for each of the three groups and must provide an analysis of opportunities for improvement (see Section 2.18.7.4 and 2.18.7.5) in addition to CHOICES items specified in the protocols provided by TENNCARE. The reports shall be submitted by July 1 each year.

34. Sections 2.30.14.1, 2.30.14.5 and 2.30.14.6 shall be deleted and replaced as follows:

2.30.14.1 The CONTRACTOR shall submit a quarterly Fraud and Abuse Activities Report. This report shall summarize the results of its fraud and abuse compliance plan (see Section 2.20) and other fraud and abuse prevention, detection, reporting, and investigation measures. The report shall be submitted in the format reviewed and approved by TENNCARE (as part of the CONTRACTOR's compliance plan).

2.30.14.5 The CONTRACTOR shall submit a monthly Program Integrity Exception List report that identifies employees or contractors (as defined in Section 2.21.9) that have been reported on the HHS-OIG LEIE (List of Excluded Individuals/Entities) (http://oig.hhs.gov/fraud/exclusions/exclusions_list.asp), the CMS MED (Medicare Exclusion Database), and/or the listing of Monthly Disciplinary Actions issued by the Professional Health Board.

2.30.14.6 The CONTRACTOR shall submit a monthly List of Involuntary Terminations Report (including providers termed due to sanctions, invalid licenses, services and billing concerns, etc.) due to program integrity concerns to TENNCARE.

35. Section 2.30.15.2.2 shall be deleted and replaced as follows:

2.30.15.2.2 The CONTRACTOR shall submit an annual *Ownership and Financial Disclosure Report* (<http://www.tn.gov/tenncare/forms/disclosureownership.pdf>) to TENNCARE. This report shall include full and complete information regarding ownership, financial transactions and persons as described in Section 2.21.9 and shall be submitted March 1 of each calendar year and at other times as required by TENNCARE.

36. Section 2.30.21.2 shall be deleted and replaced as follows:

2.30.21.2 The CONTRACTOR shall submit an annual *Summary Listing of Servicing Providers*. The listing shall include, at a minimum, provider name, address, race or ethnic origin, language spoken other than English and shall be sorted by provider type (e.g., pediatrician, surgeon, etc.). The CONTRACTOR shall use the following race or ethnic origin categories: American Indian or Alaskan Native, Asian or Pacific Islander, Hispanic origin and other race/ethnic origin as indicated by TENNCARE.

37. Section 2.30.21.4.2 shall be deleted and replaced as follows:

2.30.21.4.2 A listing of all complaints filed by employees, members, providers and subcontractors in which discrimination is alleged related to the provision of and/or access to TennCare covered services provided by the CONTRACTOR. Such listing shall include, at a minimum, the identity of the party filing the complaint, the complainant's relationship to the CONTRACTOR, the circumstances of the complaint, date complaint filed, the CONTRACTOR's resolution, date of resolution, and the name of the CONTRACTOR staff person responsible for adjudication of the complaint; and

38. Section 4.3 shall be amended by adding a new Section 4.3.46 as follows:

4.3.46 Patient Protection and Affordable Care Act (PPACA).

39. Item A.9 of Section 5.20.2.2.7 shall be deleted and replaced as follows:

A.9	Failure to provide continuation or restoration of services where enrollee was receiving the service as required by TENNCARE rules or regulations, applicable state or federal law, and all court orders and consent decrees governing appeal procedures as they become effective	An amount sufficient to at least offset any savings the CONTRACTOR achieved by withholding the services and promptly reimbursing the enrollee for any costs incurred for obtaining the services at the enrollee's expense \$500 per day for each calendar day the CONTRACTOR fails to provide continuation or restoration of services as required by TENNCARE or approved by the CONTRACTOR
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40. Items B.23 and B.22 of Section 5.20.2.2.7 shall be deleted in their entirety.

41. The paragraph regarding "Supported Housing" in Attachment I shall be deleted and replaced as follows:

Supported Housing

Supported housing services refers to services rendered at facilities that are staffed twenty-four (24) hours per day, seven (7) days a week with associated mental health staff supports for individuals who require treatment services and supports in a highly structured setting. These mental health services are for priority enrollees and are intended to prepare individuals for more independent living in the community while providing an environment that allows individuals to live in community settings. Given this goal, every effort should be made to place individuals in facilities near their families and other support systems and original areas of residence. Supported housing services are mental health services and do not include the payment of room and board.

42. Attachment III shall be deleted and replaced as follows:

**ATTACHMENT III
GENERAL ACCESS STANDARDS**

In general, contractors shall provide available, accessible, and adequate numbers of institutional facilities, service locations, service sites, professional, allied, and paramedical personnel for the provision of covered services, including all emergency services, on a 24-hour-a-day, 7-day-a-week basis. At a minimum, this shall include:

- Primary Care Physician or Extender:
 - (a) Distance/Time Rural: 30 miles or 30 minutes
 - (b) Distance/Time Urban: 20 miles or 30 minutes
 - (c) Patient Load: 2,500 or less for physician; one-half this for a physician extender.
 - (d) Appointment/Waiting Times: Usual and customary practice (see definition below), not to exceed 3 weeks from date of a patient's request for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.
 - (e) Documentation/Tracking requirements:
 - + Documentation - Plans must have a system in place to document appointment scheduling times.
 - + Tracking - Plans must have a system in place to document the exchange of member information if a provider, other than the primary care provider (i.e., school-based clinic or health department clinic), provides health care.
- Specialty Care and Emergency Care: Referral appointments to specialists (e.g., specialty physician services, hospice care, home health care, substance abuse treatment, rehabilitation services, etc.) shall not exceed 30 days for routine care or 48 hours for urgent care. All emergency care is immediate, at the nearest facility available, regardless of contract. Waiting times shall not exceed 45 minutes.
- Hospitals
 - (a) Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where access time may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented to the State on the basis of community standards.
- Long-Term Care Services:

Transport distance to licensed Adult Day Care providers will be the usual and customary not to exceed 20 miles for TennCare enrollees in urban areas, not to exceed 30 miles for

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TennCare enrollees in suburban areas and not to exceed 60 miles for TennCare enrollees in rural areas except where community standards and documentation shall apply.

- General Optometry Services:
 - (a) Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where community standards and documentation shall apply.
 - (b) Appointment/Waiting Times: Usual and customary not to exceed 3 weeks for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.
- Lab and X-Ray Services:
 - (a) Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where community access standards and documentation will apply.
 - (b) Appointment/Waiting Times: Usual and customary not to exceed 3 weeks for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.
- All other services not specified here shall meet the usual and customary standards for the community.

43. Attachment VII shall be amended by deleting and replacing the following Performance Measures as described below:

	Initial appointment timeliness for behavioral health services	Behavioral Health Appointment Timeliness Report	85% of all initial appointments for behavioral health services for outpatient mental health services (MD and Non-MD) and outpatient substance abuse services shall meet the access and availability standards indicated in Attachment III and V	Average time between the intake assessment appointment and the member's next appointment scheduled or admission by type of service	Quarterly	\$2,000 for each service type for which less than 85% of all initial appointments for the specified provider types meet the access and availability standards indicated in Attachment III and V
	TENNderCare Screening	MCO encounter data	TENNderCare screening ratio, 80%	The EPSDT screening ratio, calculated by TENNCARE utilizing MCO encounter data submissions in accordance with specifications for the CMS-416 report	Annually	\$5,000 for each full percentage point TENNderCare screening ratio is below 80%

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Length of time between psychiatric hospital/RTF discharge and first subsequent mental health service that qualifies as a post-discharge service as defined in Attachment IX, Exhibit B	Post-Discharge Services Report	<p>Discharged members receive a service that qualifies as a post-discharge service as defined in Attachment IX, Exhibit B within seven (7) calendar days of discharge. The standard (benchmark) for compliance will be phased in, according to the following schedule:</p> <table border="1" data-bbox="500 533 902 695"> <thead> <tr> <th>Year (Data reporting Period)</th> <th>Benchmark</th> </tr> </thead> <tbody> <tr> <td>January – December 2011</td> <td>50%</td> </tr> <tr> <td>January – December 2012</td> <td>53%</td> </tr> <tr> <td>January – December 2013</td> <td>56%</td> </tr> <tr> <td>January – December 2014</td> <td>59%</td> </tr> <tr> <td>January - June 2015</td> <td>60%</td> </tr> </tbody> </table>	Year (Data reporting Period)	Benchmark	January – December 2011	50%	January – December 2012	53%	January – December 2013	56%	January – December 2014	59%	January - June 2015	60%	<p>(1) Number of members discharged by length of time between discharge and first service that qualifies as a post-discharge service as defined in Attachment IX, Exhibit B, determined for each month</p> <p>(2) Average length of time between hospital discharge and first service that qualifies as a post-discharge service as defined in Attachment IX, Exhibit B, determined for each month</p>	Quarterly	\$3,000 for each quarter determined to not be in compliance
Year (Data reporting Period)	Benchmark																
January – December 2011	50%																
January – December 2012	53%																
January – December 2013	56%																
January – December 2014	59%																
January - June 2015	60%																

44. Attachment VII shall be amended by deleting the performance measures based on the “Percentage of priority members who receive a behavioral health service”, the “Increase in utilization of supported employment” and the “Annual consumer satisfaction survey administered by TDMHDD”.
45. Attachment IX shall be amended by deleting and replacing Exhibits A through D as follows:

**ATTACHMENT IX, EXHIBIT A
PSYCHIATRIC HOSPITAL/RTF READMISSION REPORT**

The *Psychiatric Hospital/RTF Readmission Report* required in Section 2.30.4.1 shall include, at a minimum, the following data elements:

1. Readmission rates by age group (under 18 and 18 and over) for
 - a.) Seven (7) days
 - b.) Thirty (30) days
2. Data Analysis
3. Action plan/follow-up

ATTACHMENT IX, EXHIBIT B
POST-DISCHARGE SERVICES REPORT

The *Post-Discharge Services Report* required in Section 2.30.4.2 shall include, at a minimum, the following data elements:

1. MCO ID number
2. Number and percentage of compliance for kept appointments that occur within seven (7) calendar days of the date of discharge from psychiatric inpatient or residential treatment facility. Appointments that meet compliance include the following:
 - A. Intake
 - B. Non Urgent Services:
 - 1) MD Services (Medication Management, Psychiatric Evaluation)
 - 2) Non MD Services (Psycho- Therapy)
 - 3) Substance Abuse (SA) (SA IOP, SA therapy)
 - 4) Psychosocial Rehabilitation (Psych Rehab, Supportive Employment, Supported Housing, Illness Management and Recovery, Peer Support)
 - 5) Mental Health Case Management
 - C. Urgent Services:
 - 1) MD Services
 - 2) Non MD Services
- 3) Substance Abuse (SA IOP) or Detoxification

**ATTACHMENT IX, EXHIBIT C
BEHAVIORAL HEALTH CRISIS RESPONSE REPORT**

The Behavioral Health Crisis Response Report required in Section 2.30.4.3 shall include, at a minimum, the following data elements:

Date:
Agency Name
Total Telephone Contacts
Total Face-to-Face Contacts
Total Face-to-Face Contacts by Payor
Face-to-Face Payor Source: TennCare
Face-to-Face Payor Source: Medicare
Face-to-Face Payor Source: Commercial
Face-to-Face Payor Source: None
Total Face-to-Face Contacts by Location
Face-to-Face Location: Onsite at CMHA
Face-to-Face Location: ER
Face-to-Face Location: Jail
Face-to-Face Location: Other Offsite
Total Face-to-Face Contacts by Disposition
Disposition: Total Admitted to RMHI (acute)
Disposition: Total Admitted to Other Inpt (acute) Includes Dual Dx
GRAND TOTAL PSYCHIATRIC ADMISSIONS
Disposition: Admitted to Crisis Stabilization Unit
Disposition: Admitted to Medically Monitored Detox
Disposition: Referred to Lower Level OP Care
Disposition: Referred to Respite Services
Disposition: Referred to Other Services
Disposition: Assessed / No Need for Referral
Disposition: Consumers Refusing Referral
Total Number of Face-to-Face Contacts for C&A <18 yrs of age
Total Number of Face-to-Face Contacts for C&A 18 to <21 yrs of age
Total Number of Face-to-Face Contacts for Adults 21 yrs and older
Total Number of Behavioral Health Providers notified of Crisis (only if consumer has a provider)
Average Time of Arrival in Minutes
Barriers to Diversion: No Psychiatric Respite Accessible
Barriers to Diversion: No SA/Dual Respite Accessible
Barriers to Diversion: Consumer/Guardian Refused Respite
Barriers to Diversion: 6-404 Signed Prior to Assessment (when consumer could have been diverted if CON not signed)
Barriers to Diversion: Lack of Linkage w/Case Mgr (only if consumer has a CM)
Barriers to Diversion: Refused Referral to CSU
Barriers to Diversion: Other (only for inappropriate admissions and barrier does not fit in any other category)
Total number of successful follow-ups.
Total number of individuals reporting that crisis services were helpful during successful follow-up.

**ATTACHMENT IX, EXHIBIT D
INITIAL APPOINTMENT TIMELINESS FOR BEHAVIORAL HEALTH SERVICES REPORT**

The *Initial Appointment Timeliness for Behavioral Health Services Report* required in Section 2.30.7.5 shall include, at a minimum, the following data elements:

1. MD Services (Psychiatry):
 - a.) Reporting percentage meeting availability standard in ATTACHMENT III: GENERAL ACCESS STANDARDS, by age group (under 18 and 18 and over)
 - b.) Reporting average time between intake and initial MD service appointment by age group (under 18 and 18 and over)

2. Outpatient Non-MD Services:
 - a.) Reporting percentage meeting availability standard *in* ATTACHMENT V: ACCESS & AVAILABILITY FOR BEHAVIORAL HEALTH SERVICES, by age group (under 18 and 18 and over)
 - b.) Reporting average time between intake and initial non-MD outpatient service appointment by age group (under 18 and 18 and over)

Note: Outpatient services include: Psychosocial Rehabilitation (Psych Rehab, Supportive Employment, Supported Housing, Illness Management and Recovery, Peer Support) Mental Health Case Management, Outpatient Psychotherapy (including intensive outpatient, family/marital therapy, individual and group)

3. Outpatient Substance Abuse Treatment Services (non-Detox)
 - a.) Reporting percentage meeting availability standard in ATTACHMENT V: ACCESS & AVAILABILITY FOR BEHAVIORAL HEALTH SERVICES, by age group (under 18 and 18 and over)
 - b.) Reporting average time between intake and initial Outpatient Substance Abuse Treatment Services (non-Detox) appointment by age group (under 18 and 18 and over)

4. Data Analysis

5. Action plan/follow-up+

Amendment Number 24 (cont.)

All of the provisions of the original Agreement not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective January 1, 2011.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

BY: Mike Morn /sd
7
Commissioner

DATE: 12/3/10

**VOLUNTEER STATE HEALTH PLAN,
INC.**

BY: Sonya Nelson
*Sonya Nelson
President and Chief Executive Officer*

DATE: 11/28/10

APPROVED BY:

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

BY: M. P. Morn /rs
Commissioner

DATE: 1/6/11

APPROVED BY:

**STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY**

BY: Justin P. Wilson /mwp
*Justin P. Wilson
Comptroller*

DATE: 1/13/11

CONTRACT NOT PAID THROUGH EDISON

CONTRACT SUMMARY SHEET

RFS Number:	318.66-026	Contract Number:	FA-02-14632-23
State Agency:	Department of Finance and Administration	Division:	Bureau of TennCare
Contractor		Contract Identification Number	
VSHP (TennCare Select)		<input type="checkbox"/> V-	
		<input type="checkbox"/> C-	

Service Description

Managed Care Organization / Medically Necessary Health Care Services to the TennCare

Contract Begin Date	Contract End Date
7/1/2001	6/30/2011

Allocation Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66	4A2	134	11	<input type="checkbox"/> STARS		
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (Including ALL amendments)	
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$	18,599,868.48
2003	\$ 15,786,123.40	\$ 17,294,819.40			\$	33,079,942.80
2004	\$ 25,125,990.72	\$ 38,364,166.90			\$	63,490,156.62
2005	\$ 58,007,447.00	\$ 58,007,447.00			\$	116,014,894.00
2006	\$87,748,111.00	\$87,748,111.00			\$	\$175,496,222.00
2007	\$87,748,111.00	\$87,748,111.00			\$	\$175,496,222.00
2008	\$72,610,000.00	\$127,390,000.00			\$	\$200,000,000.00
2009	\$72,610,000.00	\$127,390,000.00			\$	\$200,000,000.00
2010	\$100,882,476.00	\$304,024,121.00			\$	\$404,906,600.00
2011	\$131,085,619.00	\$312,820,981.00			\$	\$443,906,600.00
Total:	\$ 658,358,818.35	\$ 1,172,631,687.55			\$	\$1,830,990,505.90

CFDA# 93.778 Title XIX Dept. of Health & Human Svcs. Check the box ONLY if the answer is YES:

State Fiscal Contract		Is the Contractor a SUBRECIPIENT? (per OMB A-133)	
Name:	Scott Pierce	Is the Contractor a Vendor? (per OMB A-133)	
Address:	310 Great Circle Road	Is the Fiscal Year Funding STRICTLY LIMITED?	
Phone:	Nashville, TN (615)807-6416	Is the Contractor on STARS?	
Procuring Agency Budget Officer Approval Signature		Is the Contractor's FORM W-9 ATTACHED?	
Scott Pierce		Is the Contractor's Form W-9 Filed with Accounts?	

COMPLETE FOR ALL AMENDMENTS (only)			Funding Certification
CONTRACT END DATE:	Base Contract & Prior Amendments	This Amendment ONLY	Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.
	6/30/2011	6/30/2011	
FY: 2002	\$ 18,599,868.48		
FY: 2003	\$ 33,079,942.80		
FY: 2004	\$ 63,490,156.62		
FY: 2005	\$116,014,894.00		
FY: 2006	\$175,496,222.00		
FY: 2007	\$175,151,878.00		
FY: 2008	\$200,000,000.00		
FY: 2009	\$200,000,000.00		
FY: 2010	\$404,906,600.00		
FY: 2011	\$443,906,600.00		
Total:	\$1,830,990,505.90		

JUN 18 2010
 RECEIVED

AMENDMENT NUMBER 23

**AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.**

CONTRACT NUMBER: FA-02-14632-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as specified below.

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. Section 2.7.2.8.1.5 shall be deleted and replaced as follows:

2.7.2.8.1.5 The CONTRACTOR shall ensure that Tennessee's statutory requirement for a face-to-face evaluation by a mandatory pre-screening agent (MPA), is conducted to assess eligibility for emergency involuntary admission to an RMHI (Regional Mental Health Institute) and determine whether all available less drastic alternatives services and supports are unsuitable.

2. Section 2.11.5.1 shall be deleted and replaced as follows:

2.11.5.1 At the direction of the State, the CONTRACTOR shall divert new admissions to other inpatient facilities as appropriate, utilizing the Regional Mental Health Institutes only when no other option is available.

3. Section 2.11.8.1 shall be amended by adding a new Section 2.11.8.1.3 which shall read as follows:

2.11.8.1.3 The CONTRACTOR shall notify TENNCARE when the CONTRACTOR denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.

4. Section 2.11.8.2 shall be amended by adding a new Section 2.11.8.2.3 which shall read as follows:

2.11.8.2.3 The CONTRACTOR shall notify TENNCARE when the CONTRACTOR denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.

5. Section 2.12 shall be amended by adding a new Section 2.12.16 which shall read as follows:

2.12.16 The CONTRACTOR shall comply with the Annual Coverage Assessment Act of 2010, (T.C.A. 71-5-1003 *et seq.*, 71-5-1005 *et seq.*).

2.12.16.1 The CONTRACTOR shall be prohibited from implementing across the board rate reductions to covered or excluded contract hospitals or physicians either by category or type of provider. These requirements shall also apply to services or settings of care that are ancillary to a covered or excluded hospital, including a wholly owned subsidiary or controlled affiliate of a covered or excluded hospital or hospital system, holds more than a fifty percent (50%) controlling interest in such ancillary services or settings of care, but shall not apply to any other ancillary services or settings of care. For purposes of this Section, covered or excluded contract hospitals or physicians shall be those as defined by the Annual Coverage Assessment Act of 2010.

2.12.16.2 For across the board rate reductions to ancillary services or settings of care, the CONTRACTOR shall provide appropriate notice.

2.12.16.3 For purposes of this requirement, services or settings of care that are “ancillary” shall mean, but not be limited to, ambulatory surgical facilities, outpatient treatment clinics or imaging centers, dialysis centers, home health and related services, home infusion therapy services, outpatient rehabilitation or skilled nursing services. Further, for purposes of this requirement, “physician” includes a physician licensed under title 63, chapter 6 and chapter 9 and a group practice of physicians that hold a contract the CONTRACTOR.

6. Section 2.20.2.1 and 2.20.2.3 shall be deleted and replaced as follows:

2.20.2.1 The CONTRACTOR shall cooperate with all appropriate state and federal agencies, including TBI MFCU and/or OIG, in investigating fraud and abuse. In addition, the CONTRACTOR shall fully comply with the TCA 71-5-2601 and 71-5-2603 in performance of its obligations under this Agreement. The CONTRACTOR shall report all confirmed or suspected fraud and abuse to TENNCARE and the appropriate agency as follows:

2.20.2.3 Pursuant to TCA 71-5-2603(c) the CONTRACTOR shall be subject to a civil penalty, to be imposed by the OIG, for willful failure to report fraud and abuse by recipients, enrollees, applicants, or providers to TENNCARE and OIG or TBI MFCU, as appropriate.

7. Section 2.20.2 shall be amended by adding a new Section 2.20.2.10 and renumbering the remaining subsections accordingly, including any references thereto. The new Section 2.20.2.10 shall read as follows:

2.20.2.10 The CONTRACTOR shall notify TENNCARE when the CONTRACTOR denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.

8. **The opening paragraph in Section 2.21.9 shall be amended by adding a new third sentence so that the opening paragraph of Section 2.21.9 shall read as follows:**

2.21.9 Ownership and Financial Disclosure

The CONTRACTOR shall disclose, to TENNCARE, the Comptroller General of the United States or CMS, full and complete information regarding ownership, financial transactions and persons convicted of criminal activity related to Medicare, Medicaid, or the federal Title XX programs in accordance with federal and state requirements, including Public Chapter 379 of the Acts of 1999. The CONTRACTOR shall screen their employees and contractors initially and on an ongoing monthly basis to determine whether any of them has been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded. The word “contractors” in this section shall refer to all individuals listed on the disclosure form including providers and non-providers such as board members, etc. This disclosure shall be made in accordance with the requirements in Section 2.30.15.3.2. The following information shall be disclosed:

9. **Section 2.22.6.4.14 shall be deleted in its entirety and the remaining subsections shall be renumbered as appropriate, including all references thereto.**
10. **Section 2.26.7 shall be amended by deleting the reference to Section 2.25.9 and replacing it with the reference to Section 2.25.11.**
11. **Section 2.26.12.1 shall be amended by adding the words “durable medical equipment” and shall read as follows:**

2.26.12.1 All claims for services furnished to a TennCare enrollee filed with a CONTRACTOR shall be processed by either the CONTRACTOR or by one (1) subcontractor retained by the organization for the purpose of processing claims. However, another entity can process claims related to behavioral health, vision, lab, durable medical equipment or transportation if that entity has been retained by the CONTRACTOR to arrange and provide for the delivery of said services. However, all claims processed by any subcontractor shall be maintained and submitted by the CONTRACTOR.

12. **Sections 2.30.7.6 and 2.30.7.7 shall be deleted in their entirety and the remaining subsections shall be renumbered as appropriate, including all references thereto.**
13. **Section 2.30.10.5 shall be deleted and replaced as follows:**

2.30.10.5 The CONTRACTOR shall submit a monthly *CHOICES Utilization Report*. The report shall be submitted on a monthly basis with a one (1) month lag period (e.g., March information sent in the May report) and shall include a summary overview that includes the number of CHOICES member who have not received any long-term care services within thirty (30) to fifty-nine (59) days, within sixty (60) to eighty-nine (89) days, or in ninety (90) days or more. The report shall also include detailed member data for members who have not received services in the last thirty (30) days, including the member’s name, social security number, CHOICES group, and CHOICES enrollment date; date of last long-term care service; length of time without long-term care services; whether and when long-term care services will

Amendment Number 23 (cont.)

resume; and the reason/explanation why the member has not received long-term care services.

14. Section 2.30.14 shall be amended by adding new Sections 2.30.14.4 through 2.30.14.7 as follows:

2.30.14 Fraud and Abuse Reports

- 2.30.14.1 The CONTRACTOR shall submit an annual *Fraud and Abuse Activities Report*. This report shall summarize the results of its fraud and abuse compliance plan (see Section 2.20) and other fraud and abuse prevention, detection, reporting, and investigation measures, and should cover results for the fiscal year ending June 30. The report shall be submitted by September 30 of each year in the format reviewed and approved by TENNCARE (as part of the CONTRACTOR's compliance plan).
- 2.30.14.2 The CONTRACTOR shall submit an annual fraud and abuse compliance plan (see Section 2.20.3 of this Agreement).
- 2.30.14.3 On an annual basis the CONTRACTOR shall submit its policies for employees, contractors, and agents that comply with Section 1902(a)(68) of the Social Security Act. These policies shall be submitted by July 1 of each year.
- 2.30.14.4 The CONTRACTOR shall submit an annual *Risk Assessment Report* providing results of an annual risk assessment of the CONTRACTOR's various fraud and abuse/program integrity processes. The reports shall also be submitted on an 'as needed' basis and immediately after an adverse action, including financial-related actions (such as overpayment recoupment and fines), is issued on a provider with concerns of fraud and abuse. The CONTRACTOR shall inform TENNCARE of such action and provide details of such financial action.
- 2.30.14.5 The CONTRACTOR shall submit a quarterly *Program Integrity Exception List report* that identifies employees or contractors (as defined in Section 2.21.9) that have been reported on the HHS-OIG LEIE (List of Excluded Individuals/Entities), the CMS MED (Medicare Exclusion Database), and/or the listing of Monthly Disciplinary Actions issued by the Professional Health Board. This quarterly report shall be submitted no later than the fifteenth (15th) of the month following the end of the quarter that is being reported.
- 2.30.14.6 The CONTRACTOR shall submit a monthly *List of Involuntary Terminations Report* (including providers termed due to sanctions, invalid licenses, etc.) due to fraud and abuse concerns to TENNCARE.
- 2.30.14.7 In addition to the appropriate agency as described in Section 2.20.2, the CONTRACTOR shall report all confirmed or suspected fraud and abuse to TENNCARE immediately in accordance with Section 2.20.2.

15. Section 5.3 shall be amended by adding a new Section 5.3.45 which shall read as follows:

5.3.45 TCA 71-5-1003 *et seq.*, 71-5-1005 *et seq.*

16. Section 5.20.2.2.7 shall be amended by adding new liquidated damages to Level A of the Liquidated Damages Chart as follows:

A.18	Failure to provide continuity of care consistent with the services in place prior to the member's enrollment in the CONTRACTOR's CHOICES Program for a CHOICES member transferring from another MCO or upon CHOICES implementation in the Grand Region (see Sections 2.9.2 and 2.9.3)	\$500 per day beginning on the next calendar day after default by the CONTRACTOR in addition to the cost of the services not provided
A.19	Failure to complete a comprehensive assessment, develop a plan of care, and authorize and initiate all long-term care services specified in the plan of care for a CHOICES member within specified timelines (see Section 2.9.6)	\$500 per day for each service not initiated timely beginning on the next calendar day after default by the CONTRACTOR in addition to the cost of the services not provided
A.20	Failure to develop a person-centered plan of care for a CHOICES member that includes all of the required elements, and which has been reviewed with and signed by the member or his/her representative, unless the member/representative refuses to sign which shall be documented in writing	\$500 per deficient plan of care

17. Section 5.32.1 shall be amended by deleting “, beliefs” after the word “religion”.

18. Item 4 of the CONTRACTOR requirements of “Mental Health Case Management” Service Delivery in Attachment I shall be deleted and replaced as follows:

- 4) A minimum of fifty-one (51%) of all mental health case management services should take place outside the case manager's office at the most appropriate setting;

Amendment Number 23 (cont.)

19. Attachment III shall be amended by adding the following Section regarding “Long Term Care Services” immediately following the existing Section titled “Lab and X-Ray Services” as follows:

- Long Term Care Services:

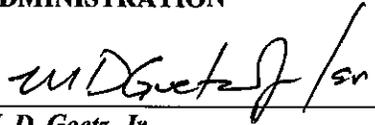
- (a) Transport distance to licensed Adult Day Care providers will be the usual and customary not to exceed 20 miles for TennCare enrollees in urban areas, not to exceed 30 miles for TennCare enrollees in suburban areas and not to exceed 60 miles for TennCare enrollees in rural areas except where community standards and documentation shall apply.

Amendment Number 23 (cont.)

All of the provisions of the original Agreement not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective July 1, 2010.

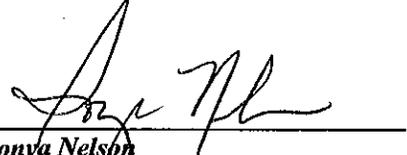
IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

BY: 
M. D. Goetz, Jr.
Commissioner

DATE: 6/16/10

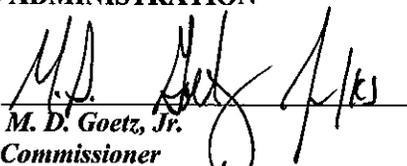
**VOLUNTEER STATE HEALTH PLAN,
INC.**

BY: 
Sonya Nelson
President and Chief Executive Officer

DATE: 6/5/10

APPROVED BY:

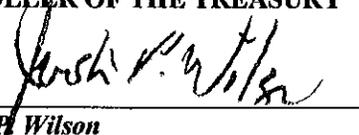
**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

BY: 
M. D. Goetz, Jr.
Commissioner

DATE: 6/22/10

APPROVED BY:

**STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY**

BY: 
Justin E. Wilson
Comptroller

DATE: 6/30/10

CONTRACT NOT PAID THROUGH EDISON

CONTRACT SUMMARY SHEET

RFS Number:	318.66-026	Contract Number:	FA-02-14632-22
State Agency:	Department of Finance and Administration	Division:	Bureau of TennCare

Contractor		Contract Identification Number	
VSHP (TennCare Select)		<input type="checkbox"/> V-	
		<input type="checkbox"/> C-	

Service Description

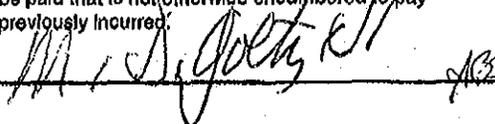
Managed Care Organization / Medically Necessary Health Care Services to the TennCare

Contract Begin Date	Contract End Date
7/1/2001	6/30/2011

Allocation Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66	4A2	134	11	<input type="checkbox"/> STARS		
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (Including ALL amendments)	
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$ 18,599,868.48	
2003	\$ 15,785,129.40	\$ 17,294,819.40			\$ 33,079,942.80	
2004	\$ 25,125,980.72	\$ 38,364,165.90			\$ 63,490,156.62	
2005	\$ 58,007,447.00	\$ 58,007,447.00			\$ 116,014,894.00	
2006	\$87,748,111.00	\$87,748,111.00			\$175,496,222.00	
2007	\$87,748,111.00	\$87,748,111.00			\$175,496,222.00	
2008	\$72,610,000.00	\$127,390,000.00			\$200,000,000.00	
2009	\$72,610,000.00	\$127,390,000.00			\$200,000,000.00	
2010	\$100,882,479.00	\$304,024,121.00			\$404,906,600.00	
2011	\$131,085,619.00	\$312,820,981.00			\$443,906,600.00	
Total:	\$ 658,358,818.95	\$ 1,172,831,887.55			\$1,830,990,505.90	

CFDA# 93.778 Title XIX Dept. of Health & Human Svcs. Check the box ONLY if the answer is YES:

State Fiscal Contract		Is the Contractor a SUBRECIPIENT? (per OMB A-133)	
Name: Scott Pierce	Address: 310 Great Circle Road	Is the Contractor a Vendor? (per OMB A-133)	
Phone: (615) 507-6015	City: Nashville, TN	Is the Fiscal Year Funding STRICTLY LIMITED?	
Procuring Agency Budget Officer Approval Signature		Is the Contractor on STARS?	
Scott Pierce		Is the Contractor's FORM W-9 ATTACHED?	
		Is the Contractor's Form W-9 Filed with Accounts?	

COMPLETE FOR ALL AMENDMENTS (only)			Funding Certification
CONTRACT END DATE:	Base Contract & Prior Amendments	This Amendment ONLY	Pursuant to T.O.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred. 
	6/30/2010	6/30/2011	
FY: 2002	\$ 18,599,868.48		
FY: 2003	\$ 33,079,942.80		
FY: 2004	\$ 63,490,156.62		
FY: 2005	\$116,014,894.00		
FY: 2006	\$175,496,222.00		
FY: 2007	\$175,151,878.00		
FY: 2008	\$200,000,000.00		
FY: 2009	\$200,000,000.00		
FY: 2010	\$400,506,600.00	\$4,400,000.00	
FY: 2011		\$443,906,600.00	
Total:	\$1,382,883,905.90	\$448,308,600.00	

OCR RELEASED

APR 19 2010

Agency
TU ACCOUNTS

AMENDMENT NUMBER 22

**AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.**

CONTRACT NUMBER: FA-02-14632-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as follows:

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. Section 1 shall be deleted and replaced as follows:

SECTION 1 - DEFINITIONS, ACRONYMS, AND ABBREVIATIONS

The terms used in this Agreement shall be given the meaning used in TennCare rules and regulations. However, the following terms when used in this Agreement, shall be construed and/or interpreted as follows, unless the context expressly requires a different construction and/or interpretation. In the event of a conflict in language between these Definitions, Attachments, and other Sections of this Agreement, the specific language in Sections 2 through 5 of this Agreement shall govern.

Administrative Cost – All costs to the CONTRACTOR related to the administration of this Agreement that are non-medical in nature including, but not limited to:

1. Meeting requirements in Sections 2.1 and 2.2;
2. Enrollment and disenrollment in accordance with Sections 2.4 and 2.5;
3. Additional services and use of incentives in Section 2.6.6;
4. Health education and outreach in Section 2.7.4;
5. Meeting requirements for coordination of services specified in Section 2.9, including care coordination for CHOICES members and the CONTRACTOR's electronic visit verification system except as otherwise provided in Section 4.6 but excluding Medical Case Management;
6. Establishing and maintaining a provider network in accordance with the requirements specified in Sections 2.11 and 3, Attachments III, IV and V;
7. Utilization Management as specified in Section 2.14;

8. Quality Management/ Quality Improvement activities as specified in Section 2.15;
9. Production and distribution of Member Materials as specified in Section 2.17;
10. Customer service requirements in Section 2.18;
11. Complaint and appeals processing and resolution in accordance with Section 2.19;
12. Determination of recoveries from third party liability resources in accordance with Section 2.21.4;
13. Claims Processing in accordance with Section 2.22;
14. Maintenance and operation of Information Systems in accordance with Section 2.23;
15. Personnel requirements in Section 2.29;
16. Production and submission of required reports as specified in Section 2.30;
17. Administration of this Agreement in accordance with policies and procedures;
18. All other Administration and Management responsibilities as specified in Attachments II through IX and Sections 2.20, 2.21, 2.24, 2.25, 2.26, 2.27, and 2.28;
19. Premium tax; and
20. All costs related to third party recovery or subrogation activities whether performed by the CONTRACTOR or a subcontractor.

Costs of subcontractors engaged solely to perform a non-medical administrative function for the CONTRACTOR specifically related to securing or fulfilling the CONTRACTOR's obligations to TENNCARE under the terms of this Agreement (e.g., claims processing) are considered to be an "administrative cost".

Adult Protective Services (APS) – An office within the Tennessee Department of Human Services that investigates reports of abuse, neglect (including self-neglect) or financial exploitation of vulnerable adults. APS staff assess the need for protective services and provide services to reduce the identified risk to the adult.

Adverse Action – Any action taken by the CONTRACTOR to deny, reduce, terminate, delay or suspend a covered service as well as any other acts or omissions of the CONTRACTOR which impair the quality, timeliness or availability of such benefits.

Affiliate – Any person, firm, corporation (including, without limitation, service corporation and professional corporation), partnership (including, without limitation, general partnership, limited partnership and limited liability partnership), limited liability company, joint venture, business trust, association or other entity or organization that now or in the future directly or indirectly controls, is controlled by, or is under common control with the CONTRACTOR.

Appeal Procedure – The process to resolve an enrollee’s right to contest verbally or in writing, any adverse action taken by the CONTRACTOR to deny, reduce, terminate, delay, or suspend a covered service as well as any other acts or omissions of the CONTRACTOR which impair the quality, timeliness or availability of such benefits. The appeal procedure shall be governed by TennCare rules and regulations and any and all applicable court orders and consent decrees.

Area Agency on Aging and Disability (AAAD) – The agency designated by the Tennessee Commission on Aging and Disability (TCAD) to develop and administer a comprehensive and coordinated community based system in, or serving, a defined planning and service area.

At-Risk – As it relates to the CHOICES program, SSI eligible adults age sixty-five (65) and older or age twenty-one (21) or older with physical disabilities, who do not meet the established level of care criteria for nursing facility services, but have a lesser number or level of functional deficits in activities of daily living as defined in TennCare rules and regulations, such that, in the absence of the provision of a moderate level of home and community based services, the individual’s condition and/or ability to continue living in the community will likely deteriorate, resulting in the need for more expensive institutional placement.

Back-up Plan – A written plan that is a required component of the plan of care for all members in CHOICES Group 2 or 3 receiving companion care or non-residential HCBS in their own home and which specifies unpaid persons as well as paid consumer-directed workers and/or contract providers (as applicable) who are available, have agreed to serve as back-up, and who will be contacted to deliver needed care in situations when regularly scheduled HCBS providers or workers are unavailable or do not arrive as scheduled. A CHOICES member or his/her representative may not elect, as part of the back-up plan, to go without services. The back-up plan shall include the names and telephone numbers of persons and agencies to contact and the services to be provided by each of the listed contacts. The member and his/her representative (as applicable) shall have primary responsibility for the development and implementation of the back-up plan for consumer directed services with assistance from the FEA as needed.

Behavioral Health Assessment – Procedures used to diagnose mental health or substance abuse conditions and determine treatment plans.

Behavioral Health Services – Mental health and/or substance abuse services.

Benefits – The package of health care services, including physical health, behavioral health, and long-term care services, that define the covered services available to TennCare enrollees enrolled in the CONTRACTOR’s MCO pursuant to this Agreement.

Best Practice Guidelines - Guidelines for provision of health and behavioral health services to children in State custody.

Best Practice Network (BPN) - A group of Best Practice Providers.

Best Practice Provider (BPP) - A provider (primary care, behavioral health, or dental) who has been determined by the state to have the interest, commitment, and competence to provide appropriate care for children in State custody, in accordance with the Remedial Plan and statewide Best Practice Guidelines, and who has agreed to be in the MCO network.

Bureau of TennCare – The division of the Tennessee Department of Finance and Administration (the single state Medicaid agency) that administers the TennCare program. For the purposes of this Agreement, Bureau of TennCare shall mean the State of Tennessee and its representatives.

Business Day – Monday through Friday, except for State of Tennessee holidays.

CAHPS (Consumer Assessment of Healthcare Providers and Systems) – A comprehensive and evolving family of surveys that ask consumers and patients to evaluate various aspects of health care.

Care Coordination Team – If an MCO elects to use a care coordination team, the care coordination team shall consist of a care coordinator and specific other persons with relevant expertise and experience who are assigned to support the care coordinator in the performance of care coordination activities for a CHOICES member as specified in this Agreement and in accordance with Section 2.9.6.

Care Coordination Unit – A specific group of staff within the MCO's organization dedicated to CHOICES that is comprised of care coordinators and care coordinator supervisors and which may also include care coordination teams.

Care Coordinator – The individual who has primary responsibility for performance of care coordination activities for a CHOICES member as specified in the Contractor Risk Agreement and meets the qualifications specified in Section 2.9.6 of the Contractor Risk Agreement.

Caregiver – For purposes of CHOICES, a person who is (a) a family member or is unrelated to the member but has a close, personal relationship with the member and (b) routinely involved in providing unpaid support and assistance to the member. A caregiver may be also designated by the member as a representative for CHOICES or for consumer direction of HCBS.

Case Manager - An organization or a provider responsible for supervising or coordinating the provision of initial and primary care to patients; for initiating and/or authorizing referrals for specialty care; and for monitoring the continuity of patient care services.

Carve-out for Children in State Custody - An arrangement that TennCare establishes so that all children in State custody are assigned to one MCO.

CEA – Cost Effective Alternative (see Section 2.6.5 of this Agreement).

Centers of Excellence (COE) for AIDS – Integrated networks designated by the State as able to provide a standardized and coordinated delivery system encompassing a range of services needed by TennCare enrollees with HIV or AIDS.

Centers of Excellence (COE) for Behavioral Health – COEs that provide a limited range of direct services to children in and at risk for State custody (i.e., not just DCS children/youth). These services are to augment the existing service system. Therefore, COEs for Behavioral Health typically only provide services where there is sufficient complexity in the case to warrant the COE for Behavioral Health resources and/or all other means to provide the service in the TennCare network have been exhausted.

Center of Excellence for Children in or at Risk of State Custody - Tertiary care academic medicine center designated by the state as possessing, or being in a position to quickly develop, expertise in pediatrics, child behavioral health issues (including aggression, depression, attachment disorders and sexualized behaviors), and the unique health care needs of children in or at risk of State custody.

CFR – Code of Federal Regulations.

Child Protective Services (CPS)– A program division of the Tennessee Department of Children’s Services whose purpose is to investigate allegations of child abuse and neglect and provide and arrange preventive, supportive, and supplementary services.

Children At Risk of State Custody - Children who are determined to belong in one of the following two groups:

1. Children at imminent risk of entering custody - Children who are at risk of entering State custody as identified pursuant to TCA 37-5-103(10).
2. Children at serious risk of entering custody - Children whom DCS has identified as a result of a CPS referral; or children whose parents or guardians are considering voluntary surrender (who come to the attention of DCS); and who are highly likely to come into custody as a result of being unable to access behavioral health services.

Children with Special Health Needs Steering Panel (CSHN Steering Panel) - An entity comprised of representatives of providers, advocates, the State, the plaintiffs of the court order related to the provision of services to children in State custody, managed care entities, and referral sites whose responsibility will be to guide and assess the development of a health service system for children in State custody, and where appropriate, make recommendations.

CHOICES Group (Group) – One of the three groups of TennCare enrollees who are enrolled in CHOICES. There are three CHOICES groups:

1. Group 1
Medicaid enrollees of all ages who are receiving Medicaid-reimbursed care in a nursing facility. As of the CHOICES implementation date for each Grand Region, the CONTRACTOR shall be responsible for providing all covered services, including nursing facility services, to members who are enrolled in CHOICES Group 1.
2. Group 2
Persons age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who meet the nursing facility level of care, who qualify for TennCare either as SSI recipients or as members of the CHOICES 217-Like HCBS Group, and who need and are receiving HCBS as an alternative to nursing facility care. The CHOICES 217-Like HCBS Group includes persons who could have been eligible under 42 CFR 435.217 had the state continued its 1915(c) HCBS waiver for elders and/or persons with physical disabilities. TENNCARE has the discretion to apply an enrollment target to this group, as described in TennCare rules and regulations. Members in CHOICES Group 2 will not be enrolled in the CONTRACTOR unless and until TENNCARE directs the CONTRACTOR to serve as a back-up health plan in one or more Grand Regions (see, e.g., Section 2.1.4 of this Agreement) and/or enroll members in CHOICES Group 2. As directed by TENNCARE, the CONTRACTOR shall implement all of the requirements in this Agreement that are applicable to CHOICES Group 2.

3. Group 3

Persons age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who qualify for TennCare as SSI recipients, who do not meet the nursing facility level of care, but who, in the absence of HCBS, are “at-risk” for nursing facility care, as defined by the State. TENNCARE has the discretion to apply an enrollment target to this group, as described in TennCare rules and regulations. Group 3 will not be included in CHOICES on the date of CHOICES implementation. TENNCARE intends to include CHOICES Group 3 on January 1, 2011 or when nursing facility level of care requirements are changed. If, at the time CHOICES Group 3 is included, TENNCARE has directed the CONTRACTOR to serve as a back-up health plan in one or more Grand Regions (see, e.g., Section 2.1.4 of this Agreement) and/or enroll members in CHOICES Group 2, TENNCARE will notify the CONTRACTOR at least sixty (60) days prior to the proposed date for including CHOICES Group 3. As of the date specified in that notice, or, if CHOICES Group 3 is included in CHOICES before the CONTRACTOR is directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, as of the date directed by TENNCARE, the CONTRACTOR shall accept members in CHOICES Group 3 and shall implement all of the requirements in this Agreement that are applicable to CHOICES Group 3.

CHOICES Implementation Date – The date, as determined by TENNCARE, when the CONTRACTOR shall begin providing long-term care services to CHOICES members.

CHOICES Member – A member who has been enrolled by TENNCARE into CHOICES.

Clean Claim – A claim received by the CONTRACTOR for adjudication that requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by the CONTRACTOR.

Clinical Practice Guidelines – Systematically developed tools or standardized specifications for care to assist practitioners and patient decisions about appropriate care for specific clinical circumstances. Such guidelines are typically developed through a formal process and are based on authoritative sources that include clinical literature and expert consensus.

Clinically Related Group 1: Severely and/or Persistently Mentally Ill (SPMI) – Persons in this group are 18 years or older with a valid DSM-IV-TR (and subsequent revisions) diagnosis excluding substance use disorders, developmental disorders or V-codes. They are recently severely impaired and the duration of their severe impairment totals six months or longer of the past year.

Clinically Related Group 2: Persons with Severe Mental Illness (SMI) – Persons in this group are 18 years or older with a valid DSM-IV-TR (and subsequent revisions) diagnosis excluding substance use disorders, developmental disorders or V-codes. Persons in this group are recently severely impaired and the duration of their severe impairment totals less than six months of the past year.

Clinically Related Group 3: Persons who are Formerly Severely Impaired – Persons in this group are 18 years or older with a valid DSM-IV-TR (and subsequent revisions) diagnosis excluding substance use disorders, developmental disorders or V-codes. Persons in this group are not recently severely impaired but have been severely impaired in the past and need services to prevent relapse.

Clinically Related Group 4: Persons with Mild or Moderate Mental Disorders – Persons in this group are 18 years or older with a valid DSM-IV-TR (and subsequent revisions) diagnosis excluding substance use disorders, developmental disorders or V-codes. Persons in this group are not recently severely impaired and are *either* not formerly severely impaired *or* are formerly severely impaired but do not need services to prevent relapse.

Clinically Related Group 5: Persons who are not in clinically related groups 1-4 as a result of their diagnosis – Persons in this group are 18 years or older diagnosed with DSM-IV-TR (and subsequent revisions) substance use disorders, developmental disorders or V-codes only.

CMS – Centers for Medicare & Medicaid Services.

Community-Based Residential Alternatives to Institutional Care (Community-Based Residential Alternatives) – Residential services that offer a cost-effective, community-based alternative to nursing facility care for persons who are elderly and/or adults with physical disabilities. This includes, but is not limited to, assisted care living facilities, adult care homes, and companion care. As provided in Section 2.6 of this Agreement, community-based residential alternatives shall be available to members in CHOICES Group 2.

Complaint – A written or verbal expression of dissatisfaction from a member about an action taken by the CONTRACTOR or service provider other than an adverse action. The CONTRACTOR shall not treat anything as a complaint that falls within the definition of adverse action.

Confidential Information – Any non-public, confidential or proprietary information, whether written, graphic, oral, electronic, visual or fixed in any tangible medium or expression, which is created under this Agreement. Any such information relating to individuals enrolled in the TennCare program (“TennCare members”), or relating to individuals who may be potentially enrolled in the TennCare program, which is provided to or obtained under this Agreement, shall also be treated as “Confidential Information” to the extent that confidential status is afforded such information under state and federal laws or regulations. All Confidential Information shall not be subject to disclosure under the Tennessee Public Records Act.

Consumer – Except when used regarding consumer direction of HCBS, an individual who uses a mental health or substance abuse service.

Consumer-Directed Worker (Worker) – An individual who has been hired by a member in CHOICES Group 2 or 3 participating in consumer direction of HCBS or his/her representative to provide one or more eligible HCBS to the member. Worker does not include an employee of an agency that is being paid by an MCO to provide HCBS to the member.

Consumer Direction of HCBS – The opportunity for a member in CHOICES Group 2 or 3 assessed to need specified types of HCBS including attendant care, personal care, homemaker, in-home respite, companion care and/or any other service specified in TennCare rules and regulations as available for consumer direction to elect to direct and manage (or to have a representative direct and manage) certain aspects of the provision of such services—primarily, the hiring, firing, and day-to-day supervision of consumer-directed workers delivering the needed service(s).

Contract Provider – A provider that is employed by or has signed a provider agreement with the CONTRACTOR to provide covered services.

Cost Neutrality Cap – The requirement that the cost of providing care to a member in CHOICES Group 2, including HCBS, home health, and private duty nursing, shall not exceed the cost of providing nursing facility services to the member, as determined in accordance with TennCare policy.

Covered Services – See Benefits.

CRG (Clinically Related Group) – Defining and classifying consumers 18 years or older into clinically related groups involves diagnosis, the severity of functional impairment, the duration of severe functional impairment, and the need for services to prevent relapse. Based on these criteria, there are five clinically related groups:

- Group 1 - Persons with Severe and Persistent Mental Illness (SPMI)
- Group 2 - Persons with Severe Mental Illness (SMI)
- Group 3 - Persons who were Formerly Severely Impaired and need services to prevent relapse
- Group 4 - Persons with Mild or Moderate Mental Disorder
- Group 5 - Persons who are not in Clinically Related Groups 1 – 4 as a result of their diagnosis being substance use disorder, developmental disorder, or V-codes

Days – Calendar days unless otherwise specified.

DCS Custody Children - Children who have been identified by DCS as belonging in one of the following groups:

1. Children in the custody of DCS—Children in the legal and physical custody of DCS whose living arrangement is provided by DCS.
2. Children in the legal, but not physical, custody of DCS—Children who are in DCS's legal custody but who reside with parents or guardians or other caretakers.

Dental Benefits Manager (DBM) – An entity responsible for the provision and administration of dental services, as defined by TENNCARE.

DHHS – United States Department of Health and Human Services.

Disenrollment – The removal of an enrollee from participation in the CONTRACTOR's MCO and deletion from the enrollment file furnished by TENNCARE to the CONTRACTOR.

Electronic Visit Verification (EVV) System – An electronic system into which provider staff and consumer-directed workers can check-in at the beginning and check-out at the end of each period of service delivery to monitor receipt of HCBS by members in CHOICES Group 2 or 3 and which may also be utilized for submission of claims.

Eligible – Any person certified by TENNCARE as eligible to receive services and benefits under the TennCare program. As it relates to CHOICES a person is eligible to receive CHOICES benefits only if he/she has been enrolled in CHOICES by TENNCARE.

Eligible HCBS – Attendant care, personal care, homemaker, in-home respite, companion care services and/or any other services specified in TennCare rules and regulations as eligible for consumer direction for which a member in CHOICES Group 2 or 3 is determined to need and elects to direct and manage (or have a representative direct and manage) certain aspects of the provision of such services – primarily the hiring, firing and day-to-day supervision of consumer-directed workers delivering the needed service(s).

Emergency Medical Condition – A physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part.

Emergency Services – Covered inpatient and outpatient services that are as follows: (1) furnished by a provider that is qualified to furnish these services; and (2) needed to evaluate or stabilize an emergency medical condition.

Employer of Record – The member in CHOICES Group 2 or 3 participating in consumer direction of HCBS or a representative designated by the member to assume the consumer direction of HCBS functions on the member's behalf.

Enrollee – A person who has been determined eligible for TennCare and who has been enrolled in the TennCare program (see Member, also).

Enrollee Marketing – Any communication, from the CONTRACTOR to a TennCare enrollee who is not enrolled in the CONTRACTOR's MCO, that can reasonably be interpreted as intended to influence the person to enroll in the CONTRACTOR's MCO, or either to not enroll in, or to disenroll from, another MCO's TennCare product.

Enrollees with Special Health Care Needs – For purposes of requirements in Section 2.9.13 of this Agreement, enrollees with special health care needs shall refer to enrollees who are in the custody of the Department of Children's Services (DCS).

Enrollment – The process by which a TennCare enrollee becomes a member of the CONTRACTOR's MCO.

EPSDT – The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) legislation and includes periodic screening, vision, dental, and hearing services. In addition, Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population. The federal regulations for EPSDT are in 42 CFR Part 441, Subpart B.

Essential Hospital Services – Tertiary care hospital services to which it is essential for the CONTRACTOR to provide access. Essential hospital services include, but are not limited to, neonatal, perinatal, pediatric, trauma and burn services.

Evidence-Based Practice – A clinical intervention that has demonstrated positive outcomes in several research studies to assist consumers in achieving their desired goals of health and wellness; specifically, the evidence-based practices recognized by the Substance Abuse and Mental Health Services Administration’s (SAMHSA) Center for Mental Health Services (CMHS).

Expenditure Cap – The annual limit on expenditures for HCBS, excluding home modifications, for CHOICES members in CHOICES Group 3. The expenditure cap is \$15,000.

Facility – Any premises (a) owned, leased, used or operated directly or indirectly by or for the CONTRACTOR or its affiliates for purposes related to this Agreement; or (b) maintained by a subcontractor or provider to provide services on behalf of the CONTRACTOR.

Fee-for-Service – A method of making payment for health services based on a fee schedule that specifies payment for defined services.

Fiscal Employer Agent (FEA) – An entity contracting with the State and/or an MCO that helps members in CHOICES Groups 2 or 3 participating in consumer direction of HCBS. The FEA provides both financial administration and supports brokerage functions for CHOICES members participating in consumer direction of HCBS. This term is used by the IRS to designate an entity operating under Section 3504 of the IRS code, Revenue Procedure 70-6 and Notice 2003-70, as the agent to members for the purpose of filing certain federal tax forms and paying federal income tax withholding, FICA and FUTA taxes. The FEA also files state income tax withholding and unemployment insurance tax forms and pays the associated taxes and processes payroll based on the eligible HCBS authorized and provided.

FQHC – Federally Qualified Health Center.

General Marketing – Any communication or activity that can reasonably be interpreted as intended to promote the CONTRACTOR, including, but not limited to, advertising, publicity, and positioning.

Grand Region – A defined geographical region that includes specified counties in which the CONTRACTOR is authorized to enroll and serve TennCare enrollees in exchange for a monthly administrative fee payment. The CONTRACTOR shall serve an entire Grand Region. The following counties constitute the Grand Regions in Tennessee:

East Grand Region – Anderson, Bledsoe, Blount, Bradley, Campbell, Carter, Claiborne, Cocke, Franklin, Grainger, Greene, Grundy, Hamblen, Hamilton, Hancock, Hawkins, Jefferson, Johnson, Knox, Loudon, Marion, McMinn, Meigs, Monroe, Morgan, Polk, Rhea, Roane, Scott, Sequatchie, Sevier, Sullivan, Unicoi, Union, and Washington Counties

Middle Grand Region – Bedford, Cannon, Cheatham, Clay, Coffee, Cumberland, Davidson, DeKalb, Dickson, Fentress, Giles, Hickman, Houston, Humphreys, Jackson, Lawrence, Lewis, Lincoln, Macon, Marshall, Maury, Montgomery, Moore, Overton, Perry, Pickett, Putnam, Robertson, Rutherford, Smith, Stewart, Sumner, Trousdale, Van Buren, Warren, Wayne, White, Williamson, and Wilson Counties

West Grand Region – Benton, Carroll, Chester, Crockett, Decatur, Dyer, Fayette, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Lake, Lauderdale, Madison, McNairy, Obion, Shelby, Tipton, and Weakley Counties

Grand Rounds – As used with respect to CHOICES members residing in a nursing facility, a planned quarterly meeting between nursing facility staff and MCO staff, including, at minimum, the care coordinator(s) assigned to residents of the facility conducted in order to: (1) address issues or concerns regarding members who have experienced a potential significant change in needs or circumstances or about whom the nursing facility or MCO has concerns (not necessarily all members who are residents of the facility); (2) identify any change in services or interventions for the members, including but not limited to changes in the members' plans of care or supplements to the members' plans of care; and (3) facilitate access to and coordination of physical health and/or behavioral health services needed by the members and to ensure the proper management of the members' acute and/or chronic conditions. At least two of the quarterly Grand Rounds per year shall be conducted on-site in the facility.

Healthcare Effectiveness Data and Information Set (HEDIS) – The most widely used set of standardized performance measures used in the managed care industry, designed to allow reliable comparison of the performance of managed health care plans. HEDIS is sponsored, supported, and maintained by the National Committee for Quality Assurance.

Health Maintenance Organization (HMO) – An entity certified by TDCI under applicable provisions of TCA Title 56, Chapter 32.

HIPAA - Health Insurance Portability and Accountability Act of 1996, 45 CFR Parts 160 and 164.

HITECH - Health Information Technology for Economic and Clinical Health Act, Pub.L.111-5, Div. A, Title XIII, § 13001(a), Feb. 17, 2009, 123 Stat. 226.

Home and Community-Based Services (HCBS) – Services not covered by Tennessee's Title XIX state plan that are provided as an alternative to long-term care institutional services in a nursing facility or an Intermediate Care Facility for the Mentally Retarded (ICF/MR). HCBS does not include home health or private duty nursing services.

Hospice – Services as described in TennCare rules and regulations and 42 CFR Part 418, which are provided to terminally ill individuals who elect to receive hospice services provided by a certified hospice agency.

Immediate Eligibility for CHOICES Group 2 – A mechanism by which the State can, based on a preliminary determination of a person’s eligibility for the CHOICES 217-Like HCBS Group, enroll the person into CHOICES Group 2 and provide immediate access to a limited package of HCBS pending a final determination of eligibility. To qualify for Immediate Eligibility for CHOICES Group 2, a person must be applying to receive covered HCBS, be determined by TENNCARE to meet nursing facility level of care, have submitted an application for financial eligibility determination to DHS, and be expected to qualify for CHOICES Group 2 based on review of the financial information provided by the applicant. Immediate Eligibility for CHOICES Group 2 shall only be for specified HCBS (no other covered services) and for a maximum of forty-five (45) days.

Immediate Eligibility – Temporary eligibility granted to a child upon entering into State custody in order to give children in State custody adequate access to medical and behavioral health services, including TENNderCare, until a final determination can be made on their TennCare eligibility.

Implementation Team - A team consisting of a physician, mental health professional(s) and other support(s) who are charged with staffing the steering panel and implementing the plan for children in State custody which has been provided and/or approved by the court as directed by TennCare.

Individually Identifiable Health Information – Any information, including demographic information, collected from an individual, that (a) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (b) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and identifies the individual; or, with respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

Information System(s) (Systems) – A combination of computing and telecommunications hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, i.e., structured data (which may include digitized audio and video) and documents as well as non-digitized audio and video; and/or (b) the processing of information and non-digitized audio and video for the purposes of enabling and/or facilitating a business process or related transaction.

Intervention – An action or ministrations that is intended to produce an effect or that is intended to alter the course of a pathologic process.

Law – Statutes, codes, rules, regulations, and/or court rulings.

Legally Appointed Representative – Any person appointed by a court of competent jurisdiction or authorized by legal process (e.g., power of attorney for health care treatment, declaration for mental health treatment) to determine the legal and/or health care interests of an individual and/or his/her estate.

Long-Term Care – The services of a nursing facility (NF), an Intermediate Care Facility for the Mentally Retarded (ICF/MR), or Home and Community-Based Services (HCBS).

Long-Term Care Ombudsman Program – A statewide program for the benefit of individuals residing in long-term care facilities, which may include nursing homes, residential homes for the aged, assisted care living facilities, and community-based residential alternatives developed by the State. The Ombudsman is available to help these individuals and their families resolve questions or problems. The program is authorized by the federal Older Americans Act and administered by the Tennessee Commission on Aging and Disability (TCAD).

Managed Care Organization (MCO) – An HMO that participates in the TennCare program.

Mandatory Outpatient Treatment (MOT) – Process whereby a person who was hospitalized for psychiatric reasons and who requires outpatient treatment can be required by a court to participate in that behavioral health outpatient treatment to prevent deterioration in his/her mental condition.

Medical Expenses – Shall be determined as follows:

1. Medical Expenses include the amount paid to providers for the provision of covered physical health, behavioral health, and/or long-term care services to members pursuant to the following listed Sections of the Agreement:
 - a. Section 2.6.1, CONTRACTOR Covered Benefits;
 - b. Section 2.6.4, Second Opinions;
 - c. Section 2.6.5, Use of Cost Effective Alternative Services;
 - d. Section 2.7, Specialized Services except TENNderCare member and provider outreach and education, health education and outreach and advance directives;
 - e. Capitated payment to licensed providers;
 - f. Medical services directed by TENNCARE or an Administrative Law Judge; and
 - g. Net impact of reinsurance coverage purchased by the CONTRACTOR.
2. Preventive Services: In order for preventive services in Section 2.6 (including, but not limited to, health education, medical case management and health promotion activities) to qualify as medical expenses, the service must be targeted to and limited to the CONTRACTOR's enrollees or targeted to meet the enrollee's individual needs and the allocation methodology for capturing said costs must be approved by TENNCARE.
3. Medical case management may qualify as medical expenses if the service is targeted to meet the enrollee's individual needs and the allocation methodology for capturing said costs is approved by TENNCARE.
4. Medical Expenses do not include:
 - a. 2.6.2 TennCare Benefits Provided by TENNCARE;
 - b. 2.6.7 Cost Sharing and Patient Liability;
 - c. 2.10 Services Not Covered;

- d. Services eligible for reimbursement by Medicare;
 - e. The activities described in or required to be conducted in Attachments II through XI, which are administrative costs; and
 - f. The two percent HMO tax.
5. Medical expenses shall be net of any TPL recoveries or subrogation activities.
6. This definition does not apply to NAIC filings.

Medical Records – All medical, behavioral health, and long-term care histories; records, reports and summaries; diagnoses; prognoses; records of treatment and medication ordered and given; X-ray and radiology interpretations; physical therapy charts and notes; lab reports; other individualized medical, behavioral health, and long-term care documentation in written or electronic format; and analyses of such information.

Member – A TennCare enrollee who enrolls in the CONTRACTOR’s MCO under the provisions of this Agreement (see Enrollee, also).

Member Month – A month of coverage for a TennCare enrollee enrolled in the CONTRACTOR’s MCO.

Mental Health Services – The diagnosis, evaluation, treatment, residential care, rehabilitation, counseling or supervision of persons who have a mental illness.

NAIC – National Association of Insurance Commissioners.

National Committee for Quality Assurance (NCQA) – A nonprofit organization committed to assessing, reporting on and improving the quality of care provided by organized delivery systems.

Non-Contract Provider – Any provider that is not directly or indirectly employed by or does not have a provider agreement with the CONTRACTOR or any of its subcontractors pursuant to the Agreement between the CONTRACTOR and TENNCARE.

Office of the Comptroller of the Treasury – The Comptroller of the Treasury is a State of Tennessee constitutional officer elected by the General Assembly for a term of two years. Statutes prescribe the comptroller's duties, the most important of which relate to audit of state and local government entities and participation in the general financial and administrative management of state government.

Office of Inspector General (OIG) – The State of Tennessee agency that investigates and may prosecute civil and criminal fraud and abuse of the TennCare program or any other violations of state law related to the operation of the TennCare program administratively, civilly or criminally.

One-Time HCBS – In-home respite, in-patient respite, assistive technology, minor home modifications, and/or pest control.

Ongoing HCBS – Community-based residential alternatives, personal care, attendant care, homemaker services, home-delivered meals, personal emergency response systems (PERS), and/or adult day care.

PASRR – Preadmission Screening and Resident Review.

Patient Liability – The amount of an enrollee’s income, as determined by DHS, to be collected each month to help pay for the enrollee’s long-term care services.

Pharmacy Benefits Manager (PBM) – An entity responsible for the provision and administration of pharmacy services.

Post-stabilization Care Services – Covered services, related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 CFR 438.114(e), to improve or resolve the member’s condition.

Prepaid Limited Health Service Organization (PLHSO) – An entity certified by TDCI under applicable provisions of TCA Title 56, Chapter 51.

Presumptive Eligibility – An established period of time (45 days) during which certain pregnant women are eligible for TennCare Medicaid. During this period of time the presumptively eligible enrollee must complete an application for Medicaid in order to stay on the program.

Primary Care Physician – A physician responsible for providing preventive and primary health care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care. A primary care physician is generally a physician who has limited his/her practice of medicine to general practice or who is an Internist, Pediatrician, Obstetrician/Gynecologist, Geriatrician, or Family Practitioner. However, as provided in Section 2.11.2.4 of this Agreement, in certain circumstances other physicians may be primary care physicians if they are willing and able to carry out all PCP responsibilities in accordance with this Agreement.

Primary Care Provider (PCP) – A primary care physician or other licensed health practitioner practicing in accordance with state law who is responsible for providing preventive and primary health care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care. A PCP may practice in various settings such as local health departments, FQHCs or community mental health agencies (CMHAs) provided that the PCP is willing and able to carry out all PCP responsibilities in accordance with this Agreement.

Primary Treatment Center (PTC) - A center developed by DCS for the purpose of providing short-term evaluation and treatment to children who have just come into custody, children already in State custody, children who have been released from State custody and who have been recommitted, and children who are at imminent risk of entering custody.

Prior Authorization – The act of authorizing specific services or activities before they are rendered or occur.

Privacy Breach – The acquisition, access, use, or disclosure of PHI in a manner which compromises the security or privacy of the PHI as governed by the provisions of HIPAA and other federal and state laws. For purposes of this definition, “compromises the security or privacy of the protected health information” means poses a significant risk of financial, reputational, or other harm to the individual.

Privacy Rule – Standards for the Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164.

Protected Health Information (PHI) – Individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.

Provider – An institution, facility, agency, physician, health care practitioner, or other entity that is licensed or otherwise authorized to provide any of the covered services in the state in which they are furnished. Provider does not include consumer-directed workers (see Consumer-Directed Worker); nor does provider include the FEA (see Fiscal Employer Agent).

Provider Agreement – An agreement, using the provider agreement template approved by TDCI, between the CONTRACTOR and a provider or between the CONTRACTOR’s subcontractor and a provider that describes the conditions under which the provider agrees to furnish covered services to the CONTRACTOR’s members.

Quality Management/Quality Improvement (QM/QI) – The development and implementation of strategies to assess and improve the performance of a program or organization on a continuous basis. This includes the identification of key measures of performance, discovery and data collection processes, identification and remediation of issues, and systems improvement activities.

Recovery – A consumer driven process in which consumers are able to work, learn and participate fully in their communities. Recovery is the ability to live a fulfilling and productive life despite a disability.

Regulatory Requirements – Any requirements imposed by applicable federal, state or local laws, rules, regulations, court orders and consent decrees, a program contract, or otherwise imposed by TENNCARE in connection with the operation of the program or the performance required by either party under an agreement.

Representative – In general, for CHOICES members, a person who is at least eighteen (18) years of age and is authorized by the member to participate in care planning and implementation and to speak and make decisions on the member’s behalf, including but not limited to identification of needs, preference regarding services and service delivery settings, and communication and resolution of complaints and concerns. As it relates to consumer direction of HCBS, a person who is authorized by the member to direct and manage the member’s worker(s), and signs a representative agreement. The representative for consumer direction of HCBS must also: be at least eighteen (18) years of age; have a personal relationship with the member and understand his/her support needs; know the member’s daily schedule and routine, medical and functional status, medication regimen, likes and dislikes, and strengths and weaknesses; and be physically present in the member’s residence on a regular basis or at least at a frequency necessary to supervise and evaluate workers.

Representative Agreement – The agreement between a member in CHOICES Group 2 or 3 electing consumer direction of HCBS who has a representative direct and manage the consumer’s worker(s) and the member’s representative that specifies the roles and responsibilities of the member and the member’s representative.

Resilience – A dynamic developmental process for children and adolescents that encompasses positive adaptation and is manifested by traits of self-efficacy, high self-esteem, maintenance of hope and optimism within the context of significant adversity.

Risk Agreement – An agreement signed by a member in CHOICES Group 2 or 3 who will receive HCBS (or his/her representative) that includes, at a minimum, identified risks to the member of residing in the community and receiving HCBS, the consequences of such risks, strategies to mitigate the identified risks, and the member’s decision regarding his/her acceptance of risk. For members electing to participate in consumer direction, the risk agreement must include any additional risks associated with the member’s decision to act as the employer of record, or to have a representative act as the employer of record on his/her behalf. See Section 2.9.6 of this Agreement for related requirements.

Routine Care – Non-urgent and non-emergency medical or behavioral health care such as screenings, immunizations, or health assessments.

Safeguarding Enrollee Information – To maintain reasonable and appropriate administrative, technical, and physical safeguards to ensure the integrity and confidentiality of the information; to protect against any reasonably anticipated threats or hazards to the security or integrity of the information; and to protect against unauthorized uses or disclosures of the information.

Savings - Residual monies remaining after the administrative costs described in this Agreement are deducted from administrative payment fees paid by TENNCARE.

Security Incident – The attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with the system operations in an information system.

Security Rule – The Final Rule adopting Security Standards for the Protection of Electronic Health Information at 45 CFR Parts 160 and 164.

Self-Direction of Health Care Tasks – A decision by a member in CHOICES Group 2 or 3 participating in consumer direction to direct and supervise a paid worker delivering eligible HCBS in the performance of health care tasks that would otherwise be performed by a licensed nurse. Self-direction of health care tasks is not a service, but rather health care-related duties and functions (such as administration of medications) that a CHOICES member participating in consumer direction may elect to have performed by a consumer-directed worker as part of the delivery of eligible HCBS s/he is authorized to receive.

Seriously Emotionally Disturbed (SED) – Seriously Emotionally Disturbed shall mean persons who have been identified by the Tennessee Department of Mental Health and Developmental Disabilities or its designee as meeting the criteria provided below:

1. Person under the age of 18; and

2. Currently, or at any time during the past year, has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV-TR (and subsequent revisions) of the American Psychiatric Association with the exception of DSM-IV-TR (and subsequent revisions) V- codes, substance use, and developmental disorders, unless these disorders co-occur with another diagnosable mental, behavioral, or emotional disturbance other than above exclusions. All of these disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity and disabling effects; and
3. The diagnosable mental, behavioral, or emotional disorder identified above has resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, and community activities. Functional impairment is defined as difficulties that substantially interfere with or limit a child or adolescent in achieving or maintaining developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills and is evidenced by a Global Assessment of Functioning (GAF) score of 50 or less in accordance with the DSM-IV-TR (and subsequent revisions). Children and adolescents who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition.

Service Agreement – The agreement between a member in CHOICES Group 2 or 3 electing consumer direction of HCBS (or the member's representative) and the member's consumer-directed worker that specifies the roles and responsibilities of the member (or the member's representative) and the member's worker.

Service Gap – A delay in initiating any long-term care service and/or a disruption of a scheduled, ongoing HCBS that was not initiated by a member, including late and missed visits.

Severely and/or Persistently Mentally Ill (SPMI) – Severely and/or Persistently Mentally Ill shall mean individuals who have been identified by the Tennessee Department of Mental Health and Developmental Disabilities or its designee as meeting the following criteria. These persons will be identified as belonging in one of the Clinically Related Groups that follow the criteria:

1. Age 18 and over; and
2. Currently, or at any time during the past year, has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified within DSM-IV-TR (and subsequent revisions) of the American Psychiatric Association, with the exception of DSM-IV-TR (and subsequent revisions) V-codes, substance use disorders, and developmental disorders, unless these disorders co-occur with another diagnosable serious mental illness other than above exclusions. All of these disorders have episodic, recurrent, or persistent features, however, they vary in terms of severity and disabling effects; and
3. The diagnosable mental, behavioral, or emotional disorder identified above has resulted in functional impairment which substantially interferes with or limits major life activities. Functional impairment is defined as difficulties that substantially interfere with or limit role functioning in major life activities including basic living skills (e.g., eating, bathing, dressing); instrumental living skills (maintaining a household, managing money, getting around in the community, taking prescribed medication); and functioning in social, family, and vocational/educational contexts. This definition includes adults who would

have met functional impairment criteria during the referenced year without the benefit of treatment or other support services.

Shall – Indicates a mandatory requirement or a condition to be met.

Span of Control – Information systems and telecommunications capabilities that the CONTRACTOR itself operates or for which it is otherwise legally responsible according to this Agreement. The CONTRACTOR's span of control also includes Systems and telecommunications capabilities outsourced by the CONTRACTOR.

Specialty Services – Includes Essential Hospital Services, services provided by Centers of Excellence, and specialty physician services.

SSA – Social Security Administration.

SSI – Supplemental Security Income.

Start Date of Operations – The date, as determined by TENNCARE, when the CONTRACTOR shall begin providing services to members.

State – The State of Tennessee, including, but not limited to, any entity or agency of the state, such as the Tennessee Department of Finance and Administration, the Office of Inspector General, the Bureau of TennCare, the Tennessee Bureau of Investigation, Medicaid Fraud Control Unit, the Tennessee Department of Mental Health and Developmental Disabilities, the Tennessee Department of Children's Services, the Tennessee Department of Health, the Tennessee Department of Commerce and Insurance, and the Office of the Attorney General.

Subcontract – An agreement entered into by the CONTRACTOR with any other organization or person who agrees to perform any administrative function or service for the CONTRACTOR specifically related to securing or fulfilling the CONTRACTOR's obligations to TENNCARE under the terms of this Agreement (e.g., claims processing, disease management) when the intent of such an agreement is to delegate the responsibility for any major service or group of services required by this Agreement. This shall also include any and all agreements between any and all subcontractors for the purposes related to securing or fulfilling the CONTRACTOR's obligations to TENNCARE under the terms of this Agreement. Agreements to provide covered services as described in Section 2.6 of this Agreement shall be considered provider agreements and governed by Section 2.12 of this Agreement.

Subcontractor – Any organization or person who provides any function or service for the CONTRACTOR specifically related to securing or fulfilling the CONTRACTOR's obligations to TENNCARE under the terms of this Agreement. Subcontractor does not include provider unless the provider is responsible for services other than those that could be covered in a provider agreement.

Substance Abuse Services – The assessment, diagnosis, treatment, detoxification, residential care, rehabilitation, education, training, counseling, referral or supervision of individuals who are abusing or have abused substances.

Supports Broker – An individual assigned by the FEA to each member in CHOICES Group 2 or 3 electing consumer-direction of HCBS who assists the member/representative in performing the employer of record functions, including, but not limited to: developing job descriptions; locating; recruiting; interviewing; scheduling; monitoring; and evaluating workers. The supports broker collaborates with, but does not duplicate, the functions of the member’s care coordinator. The supports broker does not have authority or responsibility for consumer direction. The member or member’s representative must retain authority and responsibility for consumer direction.

System Unavailability – As measured within the CONTRACTOR’s information systems span of control, when a system user does not get the complete, correct full-screen response to an input command within three (3) minutes after depressing the “Enter” or other function key.

Target Population Group (TPG) – An assessment mechanism for children and adolescents under the age of 18 to determine an individual’s level of functioning and severity of impairment due to a mental illness. Based on these criteria, there are three target population groups.

1. Target Population Group 2: Seriously Emotionally Disturbed (SED)
Children and adolescents under 18 years of age with a valid DSM-IV-TR (and subsequent revisions) diagnosis excluding substance use disorders, developmental disorders or V-codes. These children are currently severely impaired as evidenced by 50 or less Global Assessment of Functioning (GAF).
2. Target Population Group 3: At Risk of a (SED)
Children and adolescents under 18 years of age without a valid DSM-IV-TR (and subsequent revisions) diagnosis excluding substance use disorders, developmental disorders or V-codes. These children may or may not be currently seriously impaired as evidenced by Global Assessment of Functioning (GAF). These children have psychosocial issues that can potentially place them at risk of a SED.
3. Target Population Group 4: Persons who do not meet criteria TPG Group 2 or 3
Children and adolescents under 18 years of age without a valid DSM-IV-TR (and subsequent revisions) diagnosis and are not currently seriously impaired as evidenced by Global Assessment of Functioning (GAF). These children have no psychosocial issues that can potentially place them at risk of a SED.

TCA – Tennessee Code Annotated.

TENNCARE – TENNCARE shall have the same meaning as “State.”

TennCare or TennCare Program – The program administered by the single state agency, as designated by the state and CMS, pursuant to Title XIX of the Social Security Act and the Section 1115 research and demonstration waiver granted to the State of Tennessee and any successor programs.

TennCare CHOICES in Long-Term Care (CHOICES) – A program in which long-term care services for elders and/or persons with physical disabilities are integrated into TennCare’s managed care delivery system.

TennCare Medicaid Enrollee – An enrollee who qualifies and has been determined eligible for benefits in the TennCare program through Medicaid eligibility criteria as described in TennCare rules and regulations.

TennCare Standard Enrollee – An enrollee who qualifies and has been determined eligible for benefits in the TennCare program through eligibility criteria designated as “TennCare Standard” as described in the approved TennCare waiver and the TennCare rules and regulations.

TENNderCare – Tennessee’s EPSDT program; see EPSDT.

Tennessee Bureau of Investigation, Medicaid Fraud Control Unit (TBI MFCU) – The Tennessee Bureau of Investigation’s Medicaid Fraud Control Unit has the authority to investigate and prosecute (or refer for prosecution) violations of all applicable state and federal laws pertaining to fraud in the administration of the Medicaid program, the provision of medical assistance, the activities of providers of medical assistance in the state Medicaid program (TennCare), allegations of abuse or neglect of patients in health care facilities receiving payments under the state Medicaid program, misappropriation of patients’ private funds in such facilities, and allegations of fraud and abuse in board and care facilities.

Tennessee Department of Children’s Services (DCS) – The state agency responsible for child protective services, foster care, adoption, programs for delinquent youth, probation, aftercare, treatment and rehabilitation programs for identified youth, and licensing for all child-welfare agencies, except for child (day) care agencies and child support.

Tennessee Department of Commerce and Insurance (TDCI) – The state agency having the statutory authority to regulate, among other entities, insurance companies and health maintenance organizations.

Tennessee Department of Finance and Administration (F&A) – The state agency that oversees all state spending and acts as the chief corporate office of the state. It is the single state Medicaid agency. The Bureau of TennCare is a division of the Tennessee Department of Finance and Administration.

Tennessee Department of Health (DOH) – The state agency having the statutory authority to provide for health care needs in Tennessee.

Tennessee Department of Human Services (DHS) – The state agency having the statutory authority to provide human services to meet the needs of Tennesseans and enable them to achieve self-sufficiency. DHS is responsible for TennCare eligibility determinations (other than presumptive eligibility and SSI).

Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) – The state agency having the authority to provide care for persons with mental illness, substance abuse, and/or developmental disabilities.

Tertiary Pediatric Center (Center of Excellence for Children in or at risk of Custody) - A site recognized by the services it offers to be a referral site for children needing the highest level of physical care. The five recognized tertiary care centers for pediatrics are in Johnson City, Knoxville, Chattanooga, Nashville, and Memphis.

Third Party Liability (TPL) – Any amount due for all or part of the cost of medical, behavioral health, or long-term care services from a third party.

Third Party Resource – Any entity or funding source other than the enrollee or his/her responsible party, which is or may be liable to pay for all or part of the cost of health care of the enrollee.

Transition Allowance – A per member allotment not to exceed two thousand dollars (\$2,000) per lifetime which may, at the sole discretion of the CONTRACTOR, be provided as a cost-effective alternative to continued institutional care for a CHOICES member in order to facilitate transition from a nursing facility to the community when such member will, upon transition, receive more cost-effective non-residential home and community based services or companion care. Items that may be purchased or reimbursed are only those items that the member has no other means to obtain and that are essential in order to establish a community residence when such residence is not already established and to facilitate the member's safe and timely transition, including rent and/or utility deposits, essential kitchen appliances, basic furniture, and essential basic household items, such as towels, linens, and dishes.

Unsecured PHI – PHI information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary of DHHS.

USC – United States Code.

Vital MCO Documents – Consent forms and notices pertaining to the reduction, denial, delay, suspension or termination of services. All vital documents shall be available in Spanish.

Warm Transfer – A telecommunications mechanism in which the person answering the call facilitates transfer to a third party, announces the caller and issue, and remains engaged as necessary to provide assistance.

Worker – See Consumer-Directed Worker.

2. Section 2.1.4 shall be deleted and replaced as follows:

2.1.4 Demonstrate sufficient network capability and a willingness, when so directed by TENNCARE, to accept a reasonable number of enrollees enrolled, or requesting enrollment, in any MCO operating in the CONTRACTOR's service area, including any MCO that fails, is terminated in whole or in part, becomes unable to take new enrollees, maintain existing enrollment or discontinues service in the area for any reason. Notwithstanding any provision herein to the contrary, the State reserves the right to transfer enrollee members based upon the demonstrated capacity of the CONTRACTOR, when the State determines that it is in the best interests of the TennCare program.

3. Section 2.1 shall be amended by adding a new Section 2.1.5, which shall read as follows:

2.1.5 Prior to the date of implementation of CHOICES in each Grand Region and prior to the CONTRACTOR serving as a back-up health plan in one or more Grand Regions and/or enrolling members into CHOICES Group 2 and/or 3, as directed by TENNCARE, the CONTRACTOR shall demonstrate to TENNCARE's satisfaction that it is able to meet all applicable requirements. The CONTRACTOR shall cooperate in these "readiness reviews," which may include, but are not limited to, desk and on-site review of documents provided by the CONTRACTOR, a walk-through of the CONTRACTOR's

operations, system demonstrations (including systems connectivity testing), and interviews with CONTRACTOR's staff. The scope of the review may include any and all requirements of the Agreement, as determined by TENNCARE. Unless and until TENNCARE directs the CONTRACTOR to enroll members in CHOICES Group 2 and/or 3, the scope of the review for implementation of CHOICES in each Grand Region will not include requirements only applicable to CHOICES Group 2 and/or 3. Based on the results of the review activities, TENNCARE will issue a letter of findings and, if needed, will request a corrective action plan from the CONTRACTOR. TENNCARE will not enroll members into the CONTRACTOR's CHOICES program until TENNCARE has determined that the CONTRACTOR is able to meet all applicable requirements.

4. Sections 2.3 shall be deleted in its entirety and replaced with the following:

2.3 ELIGIBILITY FOR TENNCARE

2.3.1 Overview

TennCare is Tennessee's Medicaid program operating under the authority of a research and demonstration project approved by the federal government pursuant to Section 1115 of the Social Security Act. Eligibility for TennCare is determined by the State in accordance with federal requirements and state law and policy.

2.3.2 Eligibility Categories

TennCare currently consists of traditional Medicaid coverage groups (TennCare Medicaid) and an expanded population (TennCare Standard).

2.3.2.1 TennCare Medicaid

As provided in state rules and regulations, TennCare Medicaid covers all Medicaid mandatory eligibility groups as well as various optional categorically needy and medically needy groups, including children, pregnant women, the aged, and individuals with disabilities. Additional detail about eligibility criteria for covered groups is provided in state rules and regulations.

2.3.2.2 TennCare Standard

TennCare Standard includes the Standard Spend Down (SSD) population, the CHOICES 217-Like HCBS Group, and an expanded population of children. Additional detail about eligibility criteria for covered groups is provided in state rules and regulations.

2.3.3 TennCare CHOICES Groups

As specified in Section 2.6.1.5, in order to receive covered long-term care services, a member must be enrolled by TENNCARE into one of the CHOICES Groups (as defined in Section 1).

2.3.4 TennCare Applications

The CONTRACTOR shall not cause applications for TennCare to be submitted. However, as provided in Section 2.9.6.3, the CONTRACTOR shall facilitate members' eligibility determination for CHOICES enrollment.

2.3.5 Eligibility Determination and Determination of Cost Sharing

The State shall have sole responsibility for determining the eligibility of an individual for TennCare. The State shall have sole responsibility for determining the applicability of TennCare cost sharing amounts, the collection of applicable premiums, and determination of patient liability.

2.3.6 Eligibility for Enrollment in an MCO

Except for TennCare enrollees enrolled in the Program of All-Inclusive Care for the Elderly (PACE) and enrollees who are only receiving assistance with Medicare cost sharing, all TennCare enrollees will be enrolled in an MCO, including TennCare Select.

5. Section 2.4 shall be deleted in its entirety and replaced with the following:

2.4 ENROLLMENT IN AN MCO

2.4.1 General

TENNCARE is solely responsible for enrollment of TennCare enrollees in an MCO. The TennCare Bureau has identified groups of enrollees who may become members of TennCare Select. TennCare enrollees not in one of the identified groups cannot request to enroll in TennCare Select. Eligibility determination and enrollment of TennCare eligible enrollees in the CONTRACTOR's MCO shall be the sole responsibility of TENNCARE. For purposes of this Agreement, TENNCARE may define enrollees in specified categories for purposes of payments to the CONTRACTOR and/or enrollee eligibility for specified levels of services and benefits as well as cost share responsibilities.

2.4.2 Authorized Service Area

2.4.2.1 Grand Region

Enrollees will be enrolled in MCOs by Grand Region(s) of the state. The specific counties in each Grand Region are listed in Section 1 of this Agreement.

2.4.2.2 CONTRACTOR's Authorized Service Area

In addition to enrollees described in Group 5, the CONTRACTOR is authorized under this Agreement to serve enrollees who reside in the Grand Region(s) specified below:

X East Grand Region X Middle Grand Region X West Grand Region

2.4.3 **Maximum Enrollment**

The CONTRACTOR shall maintain sufficient capacity to provide services in accordance with the requirements of this Agreement for up to 300,000 enrollees or the actual number of enrollees enrolled, whichever is greater. This provision is not intended to guarantee enrollment of 300,000 enrollees, nor limit enrollment to 300,000 enrollees. Rather, it is intended to demonstrate the CONTRACTOR's ability and readiness to serve as back-up health plan in the event of a failure of a risk MCO, including any MCO which is terminated in whole or in part, becomes unable to take new enrollees, maintain existing enrollment or discontinues service in the area for any reason. Notwithstanding any provision herein to the contrary, the State reserves the right to transfer enrollee members based upon the demonstrated capacity of the CONTRACTOR, when the State determines that it is in the best interests of the TennCare program.

2.4.4 **Enrollment Criteria for TennCare Select**

2.4.4.1 General

TENNCARE shall enroll the following individuals determined eligible for TennCare and eligible for enrollment in an MCO under the authority of a 1915(b) waiver to be enrolled in TennCare Select.

2.4.4.1.1 *Eligible Groups*

2.4.4.1.1.1 **Group 1.A:** Children who are in DCS custody;

2.4.4.1.1.2 **Group 1.B:** Children who are transitioning out of DCS custody;

2.4.4.1.1.3 **Group 2:** Children under 21 who are SSI eligible;

2.4.4.1.1.4 **Group 3:** Children receiving services in an institution or receiving HCBS under a Section 1915(c) waiver program for persons with intellectual disabilities (i.e., mental retardation) in order to avoid being institutionalized;

2.4.4.1.1.5 **Group 4:** Enrollees residing out-of-state;

2.4.4.1.1.6 **Group 5:** Enrollees that have not responded to TennCare's attempts to contact and/or enrollees that are in specified Groups/Populations defined and identified by the State and agreed to by both parties;

2.4.4.1.1.7 **Group 5^{IHDSM}:** Persons with Intellectual Disabilities who have been defined as the Target Population for the Integrated Health Services Delivery Model described in Section 3A of this Agreement; and

2.4.4.1.1.8 **Group 6:** Enrollees residing in areas with insufficient capacity in other TennCare MCOs.

2.4.4.1.2 *Assignment Criteria*

2.4.4.1.2.1 TennCare eligible enrollees in groups 1 through 5^{IHDSM} will be enrolled in the CONTRACTOR's MCO independent of other TennCare eligible enrollees in the same household.

- 2.4.4.1.2.2 To the extent possible, TENNCARE shall enroll all enrollees in Group 6 in the same household in the CONTRACTOR's MCO.
- 2.4.4.1.2.3 Children eligible for TennCare as a result of being eligible for SSI will be assigned to the CONTRACTOR's MCO but may opt-out and choose another MCO.
- 2.4.4.1.2.4 TennCare enrollees who are children in the custody of the Department of Children's Services (DCS) will be enrolled in TennCare Select. When these enrollees exit State custody, they remain enrolled in TennCare Select for a specified period of time and then are disenrolled from TennCare Select. After disenrollment from TennCare Select, if the enrollee has a family member in an MCO (other than TennCare Select) he/she will be enrolled in that MCO. Otherwise, the enrollee will be given the opportunity to select another MCO. If the enrollee does not select another MCO, he/she will be assigned to an MCO (other than TennCare Select) using the default logic in the auto assignment process (see Section 2.4.4.2 below).
- 2.4.4.1.2.5 TENNCARE may allow enrollment of new TennCare enrollees in TennCare Select if there is insufficient capacity in other MCOs.

2.4.4.1.3 *Assignment Provisions for Children in State Custody*

To decrease the likelihood of recidivism, the enrollment period for children in Group 1.A who are transitioning out of State custody shall be extended by a period to be determined by TENNCARE. Children will be assigned to Group 1.B during this post-custody transition period and shall continue to receive services as specified in Section 3 including access to Best Practice Network providers, unless TENNCARE does not extend the enrollment period for children transitioning out of State custody. After the post-custody period of at least the period determined by TENNCARE, children assigned to Group 1.B shall be moved as appropriate, to Groups 2-6 and shall remain a member of the new group until the following change period, or until the child loses eligibility for TennCare. At the option of the State, children deemed to be at "prolonged" risk of State custody may remain in Group 1.B or an on-going basis.

2.4.4.2 Auto Assignment

- 2.4.4.2.1 TENNCARE will auto assign an enrollee to an MCO, in specified circumstances, including but not limited to, the enrollee does not request enrollment in a specified MCO, cannot be enrolled in the requested MCO, or is an adult eligible as a result of receiving SSI benefits.
- 2.4.4.2.2 The current auto assignment process does not apply to children eligible for TennCare as a result of being eligible for SSI or children in State custody.
- 2.4.4.2.3 There are four different levels to the current auto assignment process:
 - 2.4.4.2.3.1 If the enrollee was previously enrolled with an MCO and lost TennCare eligibility for a period of two (2) months or less, the enrollee will be re-enrolled with that MCO.

- 2.4.4.2.3.2 If the enrollee has family members in an MCO (other than TennCare Select), the enrollee will be enrolled in that MCO.
- 2.4.4.2.3.3 If the enrollee is a newborn, the enrollee will be assigned to his/her mother's MCO.
- 2.4.4.2.3.4 If none of the above applies, the enrollee will be assigned using default logic that randomly assigns enrollees to MCOs (other than TennCare Select).
- 2.4.4.2.4 TENNCARE may modify the auto assignment algorithm to change or add criteria including but not limited to quality measures or cost or utilization management performance.
- 2.4.4.3 Immediate Eligibility for Children in State Custody

Until a final determination can be made on their TennCare eligibility, the CONTRACTOR shall accept notification from DCS that a child has entered State custody and adhere to the following requirements to insure that eligibility is provided. Upon receipt of notification from DCS, the CONTRACTOR shall determine whether or not the child is otherwise enrolled in TennCare. If the child is not currently enrolled, the CONTRACTOR shall immediately build a forty-five (45) day TennCare eligibility record effective on the date the child was placed in State custody and identify the child as a child in State custody, or group 1.A enrollee.
- 2.4.4.3.1 The CONTRACTOR shall generate a letter that will explain that the child has been given forty-five (45) days of coverage from their custody date, pending a final eligibility determination.
- 2.4.4.3.2 The CONTRACTOR is not required to assign a child for whom Immediate Eligibility has been established to a BPN PCP until TennCare eligibility is confirmed.
- 2.4.4.3.3 The CONTRACTOR shall fax the BPN enrollment form and a letter of notification to the DCS Case Manager.
- 2.4.4.3.4 The CONTRACTOR's BPN staff shall work with DCS to obtain a TENNderCare visit with a BPN provider within twenty-one (21) days of request but no later than thirty (30) days of enrollment.
- 2.4.4.3.5 After twenty-five (25) days of Immediate Eligibility coverage, the CONTRACTOR shall identify children whose Immediate Eligibility will end in twenty (20) days to the DCS Program Coordinator of Health Advocacy.
- 2.4.4.3.6 The child shall be eligible for the TennCare Medicaid benefit package effective on the date the child was placed in custody through the 45th day of the Immediate Eligibility period or the date of receipt of a TennCare eligibility record, whichever occurs earlier. If the CONTRACTOR receives a TennCare eligibility record prior to the end of the forty-five (45) day eligibility period, the child shall be eligible for benefits in accordance with their TennCare eligibility status effective on the date of receipt of the eligibility record.

2.4.4.4 Non-Discrimination

2.4.4.4.1 The CONTRACTOR shall accept enrollees in the order in which applications are approved and enrollees are assigned to the CONTRACTOR (whether by selection or assignment).

2.4.4.4.2 The CONTRACTOR shall accept an enrollee in the health condition the enrollee is in at the time of enrollment and shall not discriminate against individuals on the basis of health status or need for health care services.

2.4.4.5 Family Unit

If an individual is determined eligible for TennCare and has another family member already enrolled in an MCO, that individual shall be enrolled in the same MCO. This does not apply when the individual or family member is assigned to TennCare Select. If the newly enrolled family member opts to change MCOs during the 45-day change period (see Section 2.4.7.2.1), all family members in the case will be transferred to the new MCO.

2.4.5 Effective Date of Enrollment

2.4.5.1 Initial Enrollment of Current TennCare Enrollees

The effective date of initial enrollment in an MCO for current TennCare enrollees shall be the date provided on the enrollment file from TENNCARE.

2.4.5.2 Ongoing Enrollment

In general, a member's effective date of enrollment in the CONTRACTOR's MCO will be the member's effective date of eligibility for TennCare. For SSI enrollees the effective date of eligibility/enrollment is determined by the Social Security Administration in approving SSI coverage for the individual. The effective date of eligibility for other TennCare enrollees is the date of application or the date of the qualifying event (e.g., the date the spend down obligation is met for medically needy enrollees). The effective date on the enrollment file provided by TENNCARE to the CONTRACTOR shall govern regardless of the other provisions of this Section 2.4.5.2.

2.4.5.3 In the event the effective date of eligibility provided by TENNCARE or DCS to the CONTRACTOR for either the initial enrollment of current TennCare enrollees or ongoing enrollment precedes the start date of operations, the CONTRACTOR shall treat the enrollee as a member of the CONTRACTOR's MCO effective on the start date of operations.

2.4.5.4 TENNCARE will be responsible for the direct payment of claims for long-term care services provided to a CHOICES member during the member's period of TennCare eligibility prior to the implementation of CHOICES in each Grand Region.

2.4.5.5 Enrollment Prior to Notification

2.4.5.5.1 Because individuals can be retroactively eligible for TennCare, and the effective date of initial enrollment in an MCO is the effective date of eligibility or start date of operations, whichever is sooner, the effective date of enrollment may occur prior to the CONTRACTOR being notified of the person's enrollment. Therefore, enrollment of individuals in the CONTRACTOR's MCO may occur without prior notice to the CONTRACTOR or enrollee.

2.4.5.5.2 The CONTRACTOR shall not be liable for the cost of any covered services prior to the effective date of enrollment/eligibility but shall be responsible for the costs of covered services obtained on or after 12:01 a.m. on the effective date of enrollment/eligibility.

2.4.5.5.3 TENNCARE shall make payments to the CONTRACTOR from the effective date of an enrollee's date of enrollment/eligibility. TENNCARE will be responsible for the direct payment of claims for long-term care services provided to a CHOICES member during the member's period of TennCare eligibility prior to the implementation of CHOICES in each Grand Region.

2.4.5.5.4 Except for applicable TennCare cost sharing and patient liability, the CONTRACTOR shall ensure that members are held harmless for the cost of covered services provided as of the effective date of enrollment with the CONTRACTOR.

2.4.6 **Eligibility and Enrollment Data**

2.4.6.1 The CONTRACTOR shall receive, process, and update enrollment files from TENNCARE, The CONTRACTOR shall also receive, process, and update enrollment files from DCS for children in State custody who are to be given Immediate Eligibility for a forty-five (45) day period. Enrollment data shall be updated or uploaded to the CONTRACTOR's eligibility/enrollment database(s) within twenty-four (24) hours of receipt from TENNCARE/DCS.

2.4.6.2 The CONTRACTOR agrees to accept daily eligibility updates in the form and format specified by TennCare for the purpose of identifying children in State custody and children transitioning out of State custody. Until such time as an indicator for children in State custody and children transitioning out of State custody can be added to the daily eligibility updates received from TennCare, the CONTRACTOR agrees to accept and process any adhoc report mutually agreed upon by the CONTRACTOR and TennCare to facilitate timely identification of children in State custody or children transitioning out of State custody.

2.4.6.3 The CONTRACTOR shall provide an electronic eligibility file to TENNCARE as specified and in conformance to data exchange format and method standards outlined in Section 2.23.5.

2.4.7 Enrollment Period

2.4.7.1 General

2.4.7.1.1 The CONTRACTOR shall be responsible for the provision and costs of all covered physical health and behavioral health services provided to enrollees during their period of enrollment with the CONTRACTOR. The CONTRACTOR shall be responsible for the provision and costs of covered long-term care services provided to CHOICES members as of the date of CHOICES implementation in each Grand Region. Unless and until directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, only members in CHOICES Group 1 will be enrolled with the CONTRACTOR.

2.4.7.1.2 Enrollment shall begin at 12:01 a.m. on the effective date of enrollment in the CONTRACTOR's MCO and shall end at 12:00 midnight on the date that the enrollee is disenrolled from the CONTRACTOR's MCO (see Section 2.5).

2.4.7.1.3 Once enrolled in the CONTRACTOR's MCO, the member shall remain enrolled in the CONTRACTOR's MCO until or unless the enrollee is disenrolled pursuant to Section 2.5 of this Agreement.

2.4.7.2 Changing MCOs

2.4.7.2.1 *45-Day Change Period*

After becoming eligible for TennCare and enrolling in the CONTRACTOR's MCO (whether the result of selection by the enrollee or assignment by TENNCARE), enrollees selected for enrollment in the CONTRACTOR's MCO by the State in Groups 2, 3, 5, 5^{IHDSM} and 6 shall have one (1) opportunity, anytime during the forty-five (45) day period immediately following the date of enrollment with the CONTRACTOR's MCO or the date TENNCARE sends the member notice of enrollment in an MCO, whichever is later, to request to change MCOs. Enrollees in Group 6 shall only be able to request to change MCO plans during this period to the extent capacity is available in another MCO serving the region.

2.4.7.2.2 *Annual Choice Period*

2.4.7.2.2.1 TENNCARE shall provide an opportunity for members to change MCOs (excluding TennCare Select) every twelve (12) months. Children eligible for TennCare as a result of being eligible for SSI may request to enroll in another MCO or remain with TennCare Select.

2.4.7.2.2.2 Members who do not select another MCO will be deemed to have chosen to remain with their current MCO.

2.4.7.2.2.3 Enrollees who select a new MCO shall have one (1) opportunity anytime during the forty-five (45) day period immediately following the specified enrollment effective date in the newly selected MCO to request to change MCOs.

2.4.7.2.3 *Appeal Based on Hardship Criteria*

As provided in TennCare rules and regulations, members may appeal to TENNCARE to change MCOs based on hardship criteria.

2.4.7.2.4 *Additional Reasons for Disenrollment*

As provided in Section 2.5.2, a member may be disenrolled from the CONTRACTOR's MCO for the reasons specified therein.

2.4.8 Transfers from Other MCOs

2.4.8.1 The CONTRACTOR shall accept enrollees (enrolled or pending enrollment) who have been selected by the State for enrollment, from any MCO in the CONTRACTOR's service area as authorized by TENNCARE, or from any failed MCO in the CONTRACTOR's service area including any MCO which is terminated in whole or in part, may become insolvent or discontinues service, or who reside in an area in which there is insufficient capacity in risk MCOs to enroll the population. The transfer of membership may occur at any time during the year. No enrollee from another MCO shall be transferred retroactively to the CONTRACTOR except as specified in Section 2.4.9. Except as provided in Section 2.4.9, the CONTRACTOR shall not be responsible for payment of any covered services incurred by enrollees transferred to the CONTRACTOR prior to the effective date of transfer to the CONTRACTOR.

2.4.8.2 Transfers from other MCOs shall be in consideration of the maximum enrollment levels established in Section 2.4.3.

2.4.8.3 To the extent possible and practical, TENNCARE shall provide advance notice to all MCOs serving a Grand Region of the impending failure of one of the MCOs serving the Grand Region; however, failure by TENNCARE to provide advance notice shall not limit in any manner the responsibility of each MCO to accept enrollees from failed MCOs.

2.4.9 Enrollment of Newborns

This policy is only applicable to Group 6 enrollees.

2.4.9.1 TennCare-eligible newborns and their mothers, to the extent that the mother is eligible for TennCare, should be enrolled in the same MCO with the exception of newborns that are SSI eligible at birth. Newborns that are SSI eligible at birth shall be assigned to TennCare Select but may opt out and enroll in another MCO.

2.4.9.2 A newborn may be inadvertently enrolled in an MCO different than its mother. When such cases are identified by the CONTRACTOR, the CONTRACTOR shall immediately report to TENNCARE, in accordance with written procedures provided by TENNCARE, that a newborn has been incorrectly enrolled in an MCO different than its mother.

- 2.4.9.3 Upon receipt of notice from the CONTRACTOR or discovery by TENNCARE that a newborn has been incorrectly enrolled in an MCO different than its mother, TENNCARE shall immediately:
 - 2.4.9.3.1 Disenroll the newborn from the incorrect MCO;
 - 2.4.9.3.2 Enroll the newborn in the same MCO as its mother with the same effective date as when the newborn was enrolled in the incorrect MCO;
 - 2.4.9.3.3 Recoup any payments made to the incorrect MCO for the newborn; and
 - 2.4.9.3.4 Make payments only to the correct MCO for the period of coverage.
- 2.4.9.4 The MCO in which the newborn is correctly enrolled shall be responsible for the coverage and payment of covered services provided to the newborn for the full period of eligibility. Except as provided below, the MCO in which the newborn was incorrectly enrolled shall have no liability for the coverage or payment of any services during the period of incorrect MCO assignment. TENNCARE shall only be liable for the administrative fee payment to the correct MCO.
- 2.4.9.5 There are circumstances in which a newborn's mother may not be eligible for participation in the TennCare program. The CONTRACTOR shall be required to process claims received for services provided to newborns within the time frames specified in Section 2.22.4 of this Agreement. A CONTRACTOR shall not utilize any blanket policy which results in the automatic denial of claims for services provided to a TennCare-eligible newborn, during any period of enrollment in the CONTRACTOR's MCO, because the newborn's mother is not a member of the CONTRACTOR's MCO. However, it is recognized that in complying with the claims processing time frames specified in 2.22.4 of this Agreement, a CONTRACTOR may make payment for services provided to a TennCare-eligible newborn enrolled in the CONTRACTOR's MCO at the time of payment but the newborn's eligibility may subsequently be moved to another MCO. In such event, the MCO in which the newborn is first enrolled (first MCO) may submit supporting documentation to the MCO in which the newborn is moved (second MCO) and the second MCO shall reimburse the first MCO within thirty (30) calendar days of receipt of such properly documented request for reimbursement, for the amount expended on behalf of the newborn prior to the newborn's eligibility having been moved to the second MCO. Such reimbursement shall be the actual amount expended by the first MCO. The second MCO agrees that should the second MCO fail to reimburse the first MCO the actual amount expended on behalf of the newborn within thirty (30) calendar days of receipt of a properly documented request for payment, TENNCARE is authorized to deduct the amount owed from any funds due the second MCO and to reimburse the first MCO. In the event that the CONTRACTOR fails to reimburse the first MCO the actual amount expended on behalf of the newborn within thirty (30) calendar days of receipt of a properly documented request for payment, TENNCARE may assess liquidated damages as specified in Section 5.20.2. Should it become necessary for TENNCARE to intervene in such cases, both the second MCO and the first MCO agree that TENNCARE shall be held harmless by both MCOs for actions taken by TENNCARE to resolve the dispute.

2.4.10 **Information Requirements Upon Enrollment**

As described in Section 2.17 of this Agreement, the CONTRACTOR shall provide the following information to new members: a member handbook, a provider directory and an identification card. In addition, the CONTRACTOR shall provide CHOICES members with CHOICES member education materials (see Section 2.17.7).

6. Section 2.5.2 shall be amended by adding a new Sub-Section 2.5.2.3 and renumbering existing Sub-Sections accordingly, including any references thereto.

2.5.2.3 A request by the member to change MCOs based on hardship criteria (pursuant to TennCare rules and regulations) is approved by TENNCARE, and the member is enrolled in another MCO;

7. Section 2.5.5 shall be amended by adding “from an MCO” to the end of the heading to read as follows:

2.5.5 **Effective Date of Disenrollment from an MCO**

8. Section 2.6 shall be amended by deleting Section 2.6 in its entirety and replacing it with the following and renumbering all references thereto:

2.6 BENEFITS/SERVICE REQUIREMENTS AND LIMITS

2.6.1 CONTRACTOR Covered Benefits

2.6.1.1 The CONTRACTOR shall cover the physical health, behavioral health and long-term care services/benefits outlined below. Additional requirements for behavioral health services are included in Section 2.7.2 and Attachment I.

2.6.1.2 The CONTRACTOR shall integrate the delivery of physical health, behavioral health and long-term care services. This shall include but not be limited to the following:

2.6.1.2.1 The CONTRACTOR shall operate a member services toll-free phone line (see Section 2.18.1) that is used by all members, regardless of whether they are calling about physical health, behavioral health and/or long-term care services. The CONTRACTOR shall not have a separate number for members to call regarding behavioral health and/or long-term care services. The CONTRACTOR may either route the call to another entity or conduct a “warm transfer” to another entity, but the CONTRACTOR shall not require an enrollee to call a separate number regarding behavioral health and/or long-term care services.

2.6.1.2.2 If the CONTRACTOR’s nurse triage/nurse advice line is separate from its member services line, the CONTRACTOR shall comply with the requirements in Section 2.6.1.2.2 as applied to the nurse triage/nurse advice line. The number for the nurse triage/nurse advice line shall be the same for all members, regardless of whether they are calling about physical health, behavioral health and/or long-term services, and the CONTRACTOR may either route calls to another entity or conduct “warm transfers,” but the CONTRACTOR shall not require an enrollee to call a separate number.

- 2.6.1.2.3 As required in Sections 2.9.5 and 2.9.6, the CONTRACTOR shall ensure continuity and coordination among physical health, behavioral health, and long-term care services and ensure collaboration among physical health, behavioral health, and long-term care providers. For CHOICES members, the member's care coordinator shall ensure continuity and coordination of physical health, behavioral health, and long-term care services, and facilitate communication and ensure collaboration among physical health, behavioral health, and long-term care providers.
- 2.6.1.2.4 Each of the CONTRACTOR's disease management programs (see Section 2.8) shall address the needs of members who have co-morbid physical health and behavioral health conditions.
- 2.6.1.2.5 As required in Section 2.9.5.2.2, the CONTRACTOR shall provide MCO case management to non-CHOICES members with co-morbid physical health and behavioral health conditions. These members should have a single case manager that is trained to provide MCO case management to enrollees with co-morbid physical health and behavioral health conditions. If a member with co-morbid physical and behavioral health conditions does not have a single case manager, the CONTRACTOR shall ensure, at a minimum, that the member's MCO case managers collaborate and communicate in an effective and ongoing manner. As required in Section 2.9.6.1.8 of this Agreement, the CONTRACTOR shall ensure that upon enrollment into CHOICES, MCO case management activities are integrated with CHOICES care coordination processes and functions, and that the member's assigned care coordinator has primary responsibility for coordination of all the member's physical health, behavioral health, and long-term care needs. The member's care coordinator may use resources and staff from the CONTRACTOR's case management program, including persons with specialized expertise in areas such as behavioral health, to supplement but not supplant the role and responsibilities of the member's care coordinator/care coordination team. The CONTRACTOR shall report on its case management activities per requirements in Section 2.30.6.1.
- 2.6.1.2.6 If the CONTRACTOR uses different Systems for physical health services, behavioral health and/or long-term care services, these systems shall be interoperable. In addition, the CONTRACTOR shall have the capability to integrate data from the different systems.
- 2.6.1.2.7 The CONTRACTOR's administrator/project director (see Section 2.29.1.3.1) shall be the primary contact for TENNCARE regarding all issues, regardless of the type of service, and shall not direct TENNCARE to other entities. The CONTRACTOR's administrator/project director shall coordinate with the CONTRACTOR's senior executive psychiatrist who oversees behavioral health activities (see Section 2.29.1.3.4 of this Agreement) for all behavioral health issues and the senior executive responsible for CHOICES activities (see Section 2.29.1.3.5 of this Agreement) for all issues pertaining to the CHOICES program.

2.6.1.3 CONTRACTOR Physical Health Benefits Chart

SERVICE	BENEFIT LIMIT
Inpatient Hospital Services	<p>Medicaid/Standard Eligible, Age 21 and older: As medically necessary. Inpatient rehabilitation hospital facility services are not covered for adults unless determined by the CONTRACTOR to be a cost effective alternative (see Section 2.6.5).</p> <p>Medicaid/Standard Eligible, Under age 21: As medically necessary, including rehabilitation hospital facility.</p>
Outpatient Hospital Services	As medically necessary.
Physician Inpatient Services	As medically necessary.
Physician Outpatient Services/Community Health Clinic Services/Other Clinic Services	As medically necessary.
TENNderCare Services	<p>Medicaid/Standard Eligible, Age 21 and older: Not covered.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary, except that the screenings do not have to be medically necessary. Children may also receive screenings in-between regular checkups if a parent or caregiver believes there is a problem.</p> <p>Screening, interperiodic screening, diagnostic and follow-up treatment services as medically necessary in accordance with federal and state requirements. See Section 2.7.6.</p>
Preventive Care Services	As described in Section 2.7.5.
Lab and X-ray Services	As medically necessary.
Hospice Care	As medically necessary. Shall be provided by a Medicare-certified hospice.

SERVICE	BENEFIT LIMIT
<p>Dental Services</p>	<p>Dental Services shall be provided by the Dental Benefits Manager or in some cases, through an HCBS waiver program for persons with intellectual disabilities (i.e., mental retardation).</p> <p>However, the facility, medical and anesthesia services related to the dental service that are not provided by a dentist or in a dentist’s office shall be covered services provided by the CONTRACTOR when the dental service is covered by the DBM or through an HCBS waiver program for persons with intellectual disabilities (i.e., mental retardation).</p>
<p>Vision Services</p>	<p>Medicaid/Standard Eligible, Age 21 and older: Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of refractive state), shall be covered as medically necessary. Routine periodic assessment, evaluation, or screening of normal eyes and examinations for the purpose of prescribing fitting or changing eyeglass and/or contact lenses are not covered. One pair of cataract glasses or lenses is covered for adults following cataract surgery.</p> <p>Medicaid/Standard Eligible, Under age 21: Preventive, diagnostic, and treatments services (including eyeglasses) are covered as medically necessary in accordance with TENNderCare requirements.</p>
<p>Home Health Care</p>	<p>Medicaid /Standard Eligible, Age 21 and older: Covered as medically necessary and in accordance with the definition of Home Health Care at Rule 1200-13-13-.01 (for TennCare Medicaid) and Rule 1200-13-14-.01 (for TennCare Standard). Prior authorization required for home health nurse and home health aide services, as described in Rule 1200-13-13-.04 (for TennCare Medicaid) and 1200-13-14-.04 (for TennCare Standard).</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with the definition of Home Health Care at Rule 1200-13-13-.01 (for TennCare Medicaid) and Rule 1200-13-14-.01 (for TennCare Standard). Prior authorization required for home health nurse and home health aide services, as described in Rule 1200-13-13-.04 (for TennCare Medicaid) and 1200-13-14-.04 (for TennCare Standard).</p>

SERVICE	BENEFIT LIMIT
<p>Pharmacy Services</p>	<p>Pharmacy services shall be provided by the Pharmacy Benefits Manager (PBM), unless otherwise described below.</p> <p>The CONTRACTOR shall be responsible for reimbursement of injectable drugs obtained in an office/clinic setting and to providers providing both home infusion services and the drugs and biologics. The CONTRACTOR shall require that all home infusion claims contain National Drug Code (NDC) coding and unit information to be paid.</p> <p>Services reimbursed by the CONTRACTOR shall not be included in any pharmacy benefit limits established by TENNCARE for pharmacy services (see Section 2.6.2.2).</p>
<p>Durable Medical Equipment (DME)</p>	<p>As medically necessary.</p> <p>Specified DME services shall be covered/non-covered in accordance with TennCare rules and regulations.</p>
<p>Medical Supplies</p>	<p>As medically necessary.</p> <p>Specified medical supplies shall be covered/non-covered in accordance with TennCare rules and regulations.</p>
<p>Emergency Air And Ground Ambulance Transportation</p>	<p>As medically necessary.</p>
<p>Non-emergency Medical Transportation (including Non-Emergency Ambulance Transportation)</p>	<p>Covered non-emergency medical transportation (NEMT) services are necessary non-emergency transportation services provided to convey members to and from TennCare covered services (see definition in Exhibit A to Attachment XI). Non emergency transportation services shall be provided in accordance with federal law and the Bureau of TennCare’s rules and policies and procedures. TennCare covered services (see definition in Exhibit A to Attachment XI) include services provided to a member by a non-contract or non-TennCare provider if (a) the service is covered by Tennessee’s Medicaid State Plan or Section 1115 demonstration waiver, (b) the provider could be a TennCare provider for that service, and (c) the service is covered by a third party resource (see definition in Section 1 of the Agreement).</p> <p>If a member requires assistance, an escort (as defined in TennCare rules and regulations) may accompany the member; however, only one (1) escort is allowed per member (see TennCare rules and regulations). Except for fixed route and commercial carrier transport, the CONTRACTOR shall not make separate or additional</p>

SERVICE	BENEFIT LIMIT
	<p>payment to a NEMT provider for an escort. Covered NEMT services include having an accompanying adult ride with a member if the member is under age eighteen (18). Except for fixed route and commercial carrier transport, the CONTRACTOR shall not make separate or additional payment to a NEMT provider for an adult accompanying a member under age eighteen (18).</p> <p>The CONTRACTOR is not responsible for providing NEMT to HCBS, including services provided through a 1915(c) waiver program for persons with intellectual disabilities (i.e., mental retardation) and HCBS provided through the CHOICES program. However, as specified in Section 2.11.1.8 in the event the CONTRACTOR is unable to meet the access standard for adult day care (see Attachment III) for CHOICES Group 2 or 3 members, the CONTRACTOR shall provide and pay for the cost of transportation for the member to the adult day care facility until such time the CONTRACTOR has sufficient provider capacity.</p> <p>Mileage reimbursement, car rental fees, or other reimbursement for use of a private automobile (as defined in Exhibit A to Attachment XI) is not a covered NEMT service.</p> <p>If the member is a child, transportation shall be provided in accordance with TENNderCare requirements (see Section 2.7.6.4.6).</p> <p>Failure to comply with the provisions of this Section may result in liquidated damages.</p>
Renal Dialysis Services	As medically necessary.

SERVICE	BENEFIT LIMIT
<p>Private Duty Nursing</p>	<p>Medicaid/Standard Eligible, Age 21 and older: Covered as medically necessary in accordance with the definition of Private Duty Nursing at Rule 1200-13-13-.01 (for TennCare Medicaid) and Rule 1200-13-14-.01 (for TennCare Standard), when prescribed by an attending physician for treatment and services rendered by a Registered Nurse (R.N.) or a licensed practical nurse (L.P.N.) who is not an immediate relative. Private duty nursing services are limited to services that support the use of ventilator equipment or other life sustaining technology when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are required. Prior authorization required, as described Rule 1200-13-13-.04 (for TennCare Medicaid) and 1200-13-14-.04 (for TennCare Standard).</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with the definition of Private Duty Nursing at Rule 1200-13-13-.01 (for TennCare Medicaid) and 1200-13-14-.01 (for TennCare Standard) when prescribed by an attending physician for treatment and services rendered by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), who is not an immediate relative. Prior authorization required as described in Rule 1200-13-13-.04 (for TennCare Medicaid) and 1200-13-14-.04 (for TennCare Standard).</p>
<p>Speech Therapy</p>	<p>Medicaid/Standard Eligible, Age 21 and older: Covered as medically necessary by a Licensed Speech Therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic or personality disorder.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with TENNderCare requirements.</p>
<p>Occupational Therapy</p>	<p>Medicaid/Standard Eligible, Age 21 and older: Covered as medically necessary when provided by a Licensed Occupational Therapist to restore, improve, or stabilize impaired functions.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with TENNderCare requirements.</p>

SERVICE	BENEFIT LIMIT
Physical Therapy	<p>Medicaid/Standard Eligible, Age 21 and older: Covered as medically necessary when provided by a Licensed Physical Therapist to restore, improve, or stabilize impaired functions.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with TENNderCare requirements.</p>
Organ and Tissue Transplant And Donor Organ Procurement	<p>Medicaid/Standard Eligible, Age 21 and older: All medically necessary and non-investigational/experimental organ and tissue transplants, as covered by Medicare, are covered. These include, but may not be limited to: Bone marrow/Stem cell; Cornea; Heart; Heart/Lung; Kidney; Kidney/Pancreas; Liver; Lung; Pancreas; and Small bowel/Multi-visceral.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with TENNderCare requirements. Experimental or investigational transplants are not covered.</p>
Reconstructive Breast Surgery	<p>Covered in accordance with TCA 56-7-2507, which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy, as well as surgical procedures on the non-diseased breast to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast to establish symmetry with the diseased breast shall only be covered if the surgical procedure performed on a non-diseased breast occurs within five (5) years of the date the reconstructive breast surgery was performed on a diseased breast.</p>
Chiropractic Services	<p>Medicaid/Standard Eligible, Age 21 and older: Not covered unless determined by the CONTRACTOR to be a cost effective alternative (see Section 2.6.5).</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with TENNderCare requirements.</p>

2.6.1.4 CONTRACTOR Behavioral Health Benefits Chart

SERVICE	BENEFIT LIMIT
Psychiatric Inpatient Hospital Services (including physician services)	As medically necessary.
24-hour Psychiatric Residential Treatment	<p>Medicaid/Standard Eligible, Age 21 and older: As medically necessary.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary.</p>
Outpatient Mental Health Services (including physician services)	As medically necessary.
Inpatient, Residential & Outpatient Substance Abuse Benefits¹	<p>Medicaid/Standard Eligible, Age 21 and older: Limited to ten (10) days detox, \$30,000 in medically necessary lifetime benefits unless otherwise described in the 2008 Mental Health Parity Act as determined by TENNCARE.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary.</p>
Mental Health Case Management	As medically necessary.
Psychiatric-Rehabilitation Services	As medically necessary.
Behavioral Health Crisis Services	As necessary.
Lab and X-ray Services	As medically necessary.
Non-emergency Medical Transportation (including Non-Emergency Ambulance Transportation)	Same as for physical health (see Section 2.6.1.3 above).

¹When medically appropriate, services in a licensed substance abuse residential treatment facility may be substituted for inpatient substance abuse services. Methadone clinic services are not covered for adults.

2.6.1.5 Long-Term Care Benefits for CHOICES Members

2.6.1.5.1 In addition to physical health benefits (see Section 2.6.1.3) and behavioral health benefits (see Section 2.6.1.4), the CONTRACTOR shall provide long-term care services (including HCBS and nursing facility care) as described in this Section 2.6.1.5 to members who have been enrolled into CHOICES by TENNCARE, as shown in the enrollment file furnished by TENNCARE to the CONTRACTOR, effective upon the CHOICES Implementation Date (see Section 1) for each Grand Region. Unless and until directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, only members in CHOICES Group 1 will be enrolled with the CONTRACTOR. Therefore, unless and until directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the requirements in Section 2.6.1.5 applicable only to CHOICES Group 2 and/or 3 will not apply. When directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the CONTRACTOR shall, as directed by TENNCARE, comply with all of the requirements in Section 2.6.1.5.

2.6.1.5.2 TennCare enrollees will be enrolled by TENNCARE into CHOICES if the following conditions, at a minimum, are met:

2.6.1.5.2.1 TENNCARE or its designee determines the enrollee meets the categorical and financial eligibility criteria for CHOICES Group 1, 2 or 3;

2.6.1.5.2.2 For CHOICES Groups 1 and 2, TENNCARE determines that the enrollee meets nursing facility level of care;

2.6.1.5.2.3 For CHOICES Group 2, the CONTRACTOR or, for new TennCare applicants, TENNCARE or its designee, determines that the enrollee's combined HCBS, private duty nursing and home health care can be safely provided at a cost less than the cost of nursing facility care for the member;

2.6.1.5.2.4 For CHOICES Group 3, TENNCARE determines that the enrollee meets the at-risk level of care; and

2.6.1.5.2.5 For CHOICES Groups 2 and 3, if there is an enrollment target, TENNCARE determines that the enrollment target has not been met or, for CHOICES Group 2, approves the CONTRACTOR's request to provide HCBS as a cost effective alternative (see Section 2.6.5). Enrollees transitioning from a nursing facility to the community will not be subject to the enrollment target for CHOICES Group 2 but must meet categorical and financial eligibility for CHOICES Group 2.

2.6.1.5.3 For persons enrolled in CHOICES Group 2 as a result of Immediate Eligibility for CHOICES Group 2 (as defined in Section 1 of this Agreement), the CONTRACTOR shall provide a limited package of HCBS (personal care, attendant care, homemaker services, home-delivered meals, PERS, adult day care, and/or any other services as specified in TennCare rules and regulations) as identified through a needs assessment and specified in the plan of care. Upon notice that the State has determined that the member meets categorical and financial eligibility for TennCare CHOICES, the CONTRACTOR shall authorize additional services in accordance with Section 2.9.6.2.5. For members residing in a community-based residential alternative at the time of CHOICES enrollment, authorization for community-based residential alternative services shall be retroactive to the member’s effective date of CHOICES enrollment.

2.6.1.5.4 The following long-term care services are available to CHOICES members, per Group, when the services have been determined medically necessary by the CONTRACTOR.

Service and Benefit Limit	CHOICES Group 1	CHOICES Group 2	CHOICES Group 3
Nursing facility care	X	Short-term only (up to 90 days)	Short-term only (up to 90 days)
Community-based residential alternatives		X	
Personal care visits (up to 2 visits per day)		X	X
Attendant care (up to 1080 hours per calendar year)		X	X
Homemaker services (up to 3 visits per week)		X	X
Home-delivered meals (up to 1 meal per day)		X	X
Personal Emergency Response Systems (PERS)		X	X
Adult day care (up to 2080 hours per calendar year)		X	X
In-home respite care (up to 216 hours per calendar year)		X	X
In-patient respite care (up to 9 days per calendar year)		X	X
Assistive technology (up to \$900 per calendar year)		X	X
Minor home modifications (up to \$6,000 per project; \$10,000 per		X	X
Pest control (up to 9 units per calendar year)		X	X

- 2.6.1.5.5 In addition to the benefit limits described above, in no case shall the CONTRACTOR exceed the cost neutrality cap for CHOICES Group 2 or the expenditure cap for CHOICES Group 3. For members in CHOICES Group 2, the total cost of HCBS, home health care and private duty nursing shall not exceed a member's cost neutrality cap (as defined in Section 1 of this Agreement). For members in CHOICES Group 3, the total cost of HCBS, excluding minor home modifications, shall not exceed the expenditure cap (as defined in Section 1 of this Agreement).
- 2.6.1.5.6 Members in CHOICES Groups 2 or 3 may, pursuant to Section 2.9.7, choose to participate in consumer direction of HCBS and, at a minimum, hire, fire and supervise workers of eligible HCBS.
- 2.6.1.5.7 The CONTRACTOR shall monitor CHOICES members' receipt and utilization of long-term care services, identify CHOICES members who have not received long-term care services within a thirty (30) day period of time, and notify TENNCARE regarding these members pursuant to Section 2.30.10.5. TENNCARE will investigate to determine if the member should remain enrolled in CHOICES.
- 2.6.1.5.8 The CONTRACTOR may submit to TENNCARE a request to no longer provide long-term care services to a member due to concerns regarding the ability to safely and effectively care for the member in the community and/or to ensure the member's health, safety and welfare. Acceptable reasons for this request include but are not limited to the following:
 - 2.6.1.5.8.1 A member in CHOICES Group 2 for whom the CONTRACTOR has determined that it cannot safely and effectively meet the member's needs at a cost that is less than the member's cost neutrality cap, and the member declines to transition to a nursing facility;
 - 2.6.1.5.8.2 A member in CHOICES Group 2 or 3 who repeatedly refuses to allow a care coordinator entrance into his/her place of residence (see Section 2.9.6);
 - 2.6.1.5.8.3 A member in CHOICES Group 2 or 3 who refuses to receive critical HCBS as identified through a needs assessment and documented in the member's plan of care; and
 - 2.6.1.5.8.4 A member in CHOICES Group 1 who fails to pay his/her patient liability and the CONTRACTOR is unable to find a nursing facility willing to provide services to the member (see Section 2.6.7.2).
 - 2.6.1.5.8.5 The CONTRACTOR's request to no longer provide long-term care services to a member shall include documentation as specified by TENNCARE. The State shall make any and all determinations regarding whether the CONTRACTOR may discontinue providing long-term care services to a member, disenrollment from CHOICES, and, as applicable, termination from TennCare.

2.6.2 **TennCare Benefits Provided by TENNCARE**

TennCare shall be responsible for the payment of the following benefits:

2.6.2.1 Dental Services

Except as provided in Section 2.6.1.3 of this Agreement, dental services shall not be provided by the CONTRACTOR but shall be provided by a dental benefits manager (DBM) under contract with TENNCARE. Coverage of dental services is described in TennCare rules and regulations.

2.6.2.2 Pharmacy Services

Except as provided in Section 2.6.1.3 of this Agreement, pharmacy services shall not be provided by the CONTRACTOR but shall be provided by a pharmacy benefits manager (PBM) under contract with TENNCARE. Coverage of pharmacy services is described in TennCare rules and regulations. TENNCARE does not cover pharmacy services for enrollees who are dually eligible for TennCare and Medicare.

2.6.2.3 ICF/MR Services and Alternatives to ICF/MR Services

For qualified enrollees in accordance with TennCare policies and/or TennCare rules and regulations, TENNCARE covers the costs of long-term care institutional services in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or alternative to an ICF/MR provided through a Home and Community Based Services (HCBS) waiver for persons with intellectual disabilities (i.e., mental retardation) (referred to as an ID HCBS waiver).

2.6.3 **Medical Necessity Determination**

2.6.3.1 The CONTRACTOR may establish procedures for the determination of medical necessity. The determination of medical necessity shall be made on a case by case basis and in accordance with the definition of medical necessity defined in TCA 71-5-144 and TennCare rules and regulations. However, this requirement shall not limit the CONTRACTOR's ability to use medically appropriate cost effective alternative services in accordance with Section 2.6.5.

2.6.3.2 The CONTRACTOR shall not employ, and shall not permit others acting on their behalf to employ, utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each TennCare enrollee and his/her medical history. The CONTRACTOR shall have the ability to place tentative limits on a service; however, such tentative limits placed by the CONTRACTOR shall be exceeded (up to the applicable benefit limits on behavioral health and long-term care services provided in Section 2.6.1.4 and 2.6.1.5 above) when medically necessary based on a member's individual characteristics.

2.6.3.3 The CONTRACTOR shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition.

2.6.3.4 The CONTRACTOR may deny services that are non-covered except as otherwise required by TENNderCare or unless otherwise directed to provide by TENNCARE and/or an administrative law judge.

2.6.3.5 All medically necessary services shall be covered for enrollees under twenty-one (21) years of age in accordance with TENNderCare requirements (see Section 2.7.6).

2.6.4 **Second Opinions**

The CONTRACTOR shall provide for a second opinion in any situation where there is a question concerning a diagnosis or the options for surgery or other treatment of a health condition when requested by a member, parent and/or legally appointed representative. The second opinion shall be provided by a contracted qualified health care professional or the CONTRACTOR shall arrange for a member to obtain one from a non-contract provider. The second opinion shall be provided at no cost to the member.

2.6.5 **Use of Cost Effective Alternative Services**

2.6.5.1 The CONTRACTOR shall be allowed to use cost effective alternative services, whether listed as covered or non-covered or omitted in Section 2.6.1 of this Agreement, when the use of such alternative services is medically appropriate and is cost effective. This may include, for example, use of nursing facilities as step down alternatives to acute care hospitalization or hotel accommodations for persons on outpatient radiation therapy to avoid the rigors of daily transportation. The CONTRACTOR shall comply with TennCare policies and procedures. As provided in the applicable TennCare policies and procedures, services not listed in the TennCare policies and procedures must be prior approved in writing by TENNCARE. The Medical Fund Target described elsewhere in this Agreement shall not be increased or decreased because of the use of alternative services. The CONTRACTOR shall maintain documentation that demonstrates the cost effectiveness of any non-covered services that are provided to TennCare enrollees and for which the CONTRACTOR seeks reimbursement from the State. A report summarizing all such documentation for the preceding year shall be submitted by the CONTRACTOR in accordance with Section 2.30.22.3.

2.6.5.2 For members in CHOICES Groups 2 and 3, the CONTRACTOR may choose to provide the following as a cost effective alternative to other covered services:

2.6.5.2.1 HCBS to CHOICES members who would otherwise receive nursing facility care. If a member meets categorical and financial eligibility requirements for enrollment in CHOICES Group 2 and also meets the nursing facility level of care, as determined by TENNCARE, and would otherwise remain in or be admitted to a nursing facility (as determined by the CONTRACTOR and demonstrated to the satisfaction of TENNCARE), the CONTRACTOR may, at its discretion and upon TENNCARE written prior approval, offer that member HCBS as a cost effective alternative to nursing facility care (see Section 2.9.6.3.13). In this instance, TENNCARE will enroll the member receiving HCBS as a cost effective alternative to nursing facility services in CHOICES Group 2, notwithstanding any enrollment target for CHOICES Group 2 that has been reached.

- 2.6.5.2.2 HCBS to members in CHOICES Group 2 in excess of the benefit limits described in Section 2.6.1.5.4 as a cost effective alternative to nursing facility care or covered home health services.
- 2.6.5.2.3 HCBS to members in CHOICES Group 3 in excess of the benefit limits described in Section 2.6.1.5.4 as a cost effective alternative to covered home health services. Members in CHOICES Group 3 do not meet nursing facility level of care and as such, HCBS in excess of benefit limits specified in Section 2.6.1.5.4 may not be offered as a cost effective alternative to nursing facility care.
- 2.6.5.2.4 Non-covered HCBS services to members in CHOICES Group 2 not otherwise specified in this Agreement or in applicable TennCare policies and procedures, upon written prior approval from TENNCARE.
- 2.6.5.2.5 For members in CHOICES Group 2 transitioning from a nursing facility to a community setting, a one-time transition allowance, per member. The amount of the transition allowance shall not exceed two thousand dollars (\$2,000) and may be used for items such as, but not limited to, the first month's rent and/or utility deposits, kitchen appliances, furniture, and basic household items.
- 2.6.5.2.6 For members in CHOICES Group 2 or 3, non-emergency medical transportation (NEMT) not otherwise covered by this Agreement.
- 2.6.5.3 If the CONTRACTOR chooses to provide cost effective alternative services to a member in CHOICES Group 2 or 3, in no case shall the cost of HCBS, private duty nursing and home health care for CHOICES Group 2 exceed a member's cost neutrality cap nor the total cost of HCBS, excluding minor home modifications, for members in CHOICES Group 3 exceed the expenditure cap. The total cost of HCBS includes all HCBS (whether otherwise covered or not covered) and other services that are offered as a cost effective alternative to nursing facility care, HCBS, or home health, including, as applicable, the one-time transition allowance for CHOICES Group 2 and NEMT for CHOICES Groups 2 and 3.

2.6.6 Additional Services and Use of Incentives

- 2.6.6.1 The CONTRACTOR shall not advertise any services that are not required by this Agreement other than those covered pursuant to Section 2.6.1 of this Agreement.
- 2.6.6.2 The CONTRACTOR shall not offer or provide any services other than services covered by this Agreement (see Section 2.6.1) or services provided as a cost effective alternative (see Section 2.6.5) of this Agreement. However, the CONTRACTOR may provide incentives that have been specifically prior approved in writing by TENNCARE. For example, TENNCARE may approve the use of incentives given to enrollees to encourage participation in disease management programs.

2.6.7 Cost Sharing and Patient Liability

2.6.7.1 General

The CONTRACTOR and all providers and subcontractors shall not require any cost sharing or patient liability responsibilities for covered services except to the extent

that cost sharing or patient liability responsibilities are required for those services by TENNCARE in accordance with TennCare rules and regulations, including but not limited to, holding enrollees liable for debt due to insolvency of the CONTRACTOR or non-payment by the State to the CONTRACTOR. Further, the CONTRACTOR and all providers and subcontractors shall not charge enrollees for missed appointments.

2.6.7.2 Patient Liability

2.6.7.2.1 TENNCARE will notify the CONTRACTOR of any applicable patient liability amounts for members in CHOICES Group 1 via the eligibility/enrollment file. The CONTRACTOR shall delegate collection of patient liability to the nursing facility and shall pay the facility net of the applicable patient liability amount.

2.6.7.2.2 In accordance with the involuntary discharge process, including notice and appeal (see Section 2.12.11.3), a nursing facility may refuse to continue providing services to a member who fails to pay his or her patient liability and for whom the nursing facility can demonstrate to the CONTRACTOR that it has made a good faith effort to collect payment.

2.6.7.2.3 If the CONTRACTOR is notified that a nursing facility is considering discharging a member (see Section 2.12.11.3), the CONTRACTOR shall work to find an alternate nursing facility willing to serve the member and document its efforts in the member's files.

2.6.7.2.4 If the CONTRACTOR is unable to find an alternate nursing facility willing to serve the member, and the CONTRACTOR has been directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2, and the member otherwise qualifies to enroll in CHOICES Group 2, the CONTRACTOR shall determine if it can safely and effectively serve the member in the community and within the cost neutrality cap. If it can, the member shall be offered a choice of HCBS. If the member chooses HCBS, the CONTRACTOR shall forward all relevant information to TENNCARE for a decision regarding enrollment in CHOICES Group 2 (see Section 2.9.6.3).

2.6.7.2.5 If the CONTRACTOR is unable to find an alternate nursing facility willing to serve the member and the CONTRACTOR determines that it cannot safely and effectively serve the member in the community and within the cost neutrality cap, the member declines to enroll in CHOICES Group 2, or TENNCARE denies enrollment in CHOICES Group 2, the CONTRACTOR may, pursuant to Section 2.6.1.5.8, request to no longer provide long-term care services to the member.

2.6.7.3 Preventive Services

TennCare cost sharing or patient liability responsibilities shall apply to covered services other than the preventive services described in TennCare rules and regulations.

2.6.7.4 Cost Sharing Schedule

The current TennCare cost sharing schedule is included in this Agreement as Attachment II. The CONTRACTOR shall not waive or use any alternative cost sharing schedules, unless required by TENNCARE.

2.6.7.5 Provider Requirements

2.6.7.5.1 Providers or collection agencies acting on the provider's behalf may not bill enrollees for amounts other than applicable TennCare cost sharing or patient liability amounts for covered services, including but not limited to, services that the State or the CONTRACTOR has not paid for, except as permitted by TennCare rules and regulations and as described below. Providers may seek payment from an enrollee only in the following situations.

2.6.7.5.1.1 If the services are not covered services and, prior to providing the services, the provider informed the enrollee that the services were not covered. The provider shall inform the enrollee of the non-covered service and have the enrollee acknowledge the information. If the enrollee still requests the service, the provider shall obtain such acknowledgment in writing prior to rendering the service. Regardless of any understanding worked out between the provider and the enrollee about private payment, once the provider bills an MCO for the service that has been provided, the prior arrangement with the enrollee becomes null and void without regard to any prior arrangement worked out with the enrollee.

2.6.7.5.1.2 If the enrollee's TennCare eligibility is pending at the time services are provided and if the provider informs the person they will not accept TennCare assignment whether or not eligibility is established retroactively. Regardless of any understanding worked out between the provider and the enrollee about private payment, once the provider bills an MCO for the service the prior arrangement with the enrollee becomes null and void without regard to any prior arrangement worked out with the enrollee.

2.6.7.5.1.3 If the enrollee's TennCare eligibility is pending at the time services are provided, however, all monies collected, except applicable TennCare cost sharing or patient liability amounts shall be refunded when a claim is submitted to an MCO because the provider agreed to accept TennCare assignment once retroactive TennCare eligibility was established. (The monies collected shall be refunded as soon as a claim is submitted and shall not be held conditionally upon payment of the claim.)

2.6.7.5.1.4 If the services are not covered because they are in excess of an enrollee's benefit limit, and the provider complies with applicable TennCare rules and regulations.

2.6.7.5.2 The CONTRACTOR shall require, as a condition of payment, that the provider accept the amount paid by the CONTRACTOR or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payer) plus any applicable amount of TennCare cost sharing or patient liability responsibilities due from the enrollee as payment in full for the service. Except in the circumstances described above, if the CONTRACTOR is aware that a provider, or a collection agency acting on the provider's behalf, bills an enrollee for amounts other than the applicable amount of TennCare cost sharing or patient liability responsibilities due from the enrollee, the CONTRACTOR shall notify the provider and demand that the provider and/or collection agency cease such action against the enrollee immediately. If a provider continues to bill an enrollee after notification by the CONTRACTOR, the CONTRACTOR shall refer the provider to the Tennessee Bureau of Investigation.

9. Section 2.6.8 shall be deleted in its entirety and replaced with the following:

2.6.8 Immediate Eligibility for Children in DCS Custody

Effective January 1, 2002, when a child enters DCS custody, DCS will provide the CONTRACTOR with the child's information. In order to give children in DCS adequate access to covered services, including TENNderCare, until a final determination can be made on their TennCare eligibility, the CONTRACTOR shall accept notification from DCS and adhere to the following requirements to insure that eligibility is provided. Upon receipt of notification from DCS, the CONTRACTOR shall determine whether or not the child is otherwise enrolled in TennCare. If the child is not currently enrolled, the CONTRACTOR shall immediately build a forty-five (45) day TennCare eligibility record effective on the date the child was placed in State custody and identify the child as a child in State custody, or group 1.A enrollee. The CONTRACTOR shall generate a letter that will explain that the child has been given forty-five (45) days of coverage from their custody date, pending a final eligibility determination. The CONTRACTOR is not required to assign a child for whom Immediate Eligibility has been established to a BPN PCP until TennCare eligibility is confirmed. The CONTRACTOR shall fax the BPN enrollment form and a letter of notification to the DCS Case Manager. The CONTRACTOR's BPN staff shall work with DCS to obtain a TENNderCare visit with a BPN provider within twenty-one (21) days of request but no later than thirty (30) days of enrollment. After twenty-five (25) days of Immediate Eligibility coverage, the CONTRACTOR shall identify children whose Immediate Eligibility will end in twenty (20) days to the DCS Program Coordinator of Health Advocacy. The child shall be eligible for the TennCare Medicaid benefit package effective on the date the child was placed in custody through the 45th day of the Immediate Eligibility period or the date of receipt of a TennCare eligibility record, whichever occurs earlier. If the CONTRACTOR receives a TennCare eligibility record prior to the end of the forty-five (45) day eligibility period, the child shall be eligible for benefits in accordance with their TennCare eligibility status effective on the date of receipt of the eligibility record.

In regards to TENNderCare reporting, the CONTRACTOR will continue to only report on those children whose TennCare eligibility has appeared on the DCS Tape received from TENNCARE and who are assigned to MCO 11.

10. Section 2.7 shall be amended by deleting Section 2.7 in its entirety and replacing it with the following and renumbering all references thereto:

2.7 SPECIALIZED SERVICES

2.7.1 Emergency Services

2.7.1.1 Emergency services (as defined in Section 1 of this Agreement) shall be available twenty-four (24) hours a day, seven (7) days a week.

2.7.1.2 The CONTRACTOR shall review and approve or disapprove claims for emergency services based on the definition of emergency medical condition specified in Section 1 of this Agreement. The CONTRACTOR shall base coverage decisions for emergency services on the severity of the symptoms at the time of presentation and shall cover emergency services where the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. The CONTRACTOR shall not impose restrictions on coverage of emergency services more restrictive than those permitted by the prudent layperson standard.

2.7.1.3 The CONTRACTOR shall provide coverage for inpatient and outpatient emergency services, furnished by a qualified provider, regardless of whether the member obtains the services from a contract provider, that are needed to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard. These services shall be provided without prior authorization in accordance with 42 CFR 438.114. The CONTRACTOR shall pay for any emergency screening examination services conducted to determine whether an emergency medical condition exists and for all emergency services that are medically necessary until the member is stabilized.

2.7.1.4 If an emergency screening examination leads to a clinical determination by the examining provider that an actual emergency medical condition exists, the CONTRACTOR shall pay for both the services involved in the screening examination and the services required to stabilize the member. The CONTRACTOR shall be required to pay for all emergency services which are medically necessary until the clinical emergency is stabilized. This includes all medical and behavioral health services that may be necessary to assure, within reasonable medical probability, that no material deterioration of the member's condition is likely to result from, or occur during, discharge of the member or transfer of the member to another facility. If there is a disagreement between the treating facility and the CONTRACTOR concerning whether the member is stable enough for discharge or transfer, or whether the medical benefits of an un-stabilized transfer outweigh the risks, the judgment of the attending provider(s) actually caring for the member at the treating facility prevails and is binding on the CONTRACTOR. The CONTRACTOR, however, may establish arrangements with a treating facility whereby the CONTRACTOR may send one of its own providers with appropriate emergency room privileges to assume the attending provider's responsibilities to stabilize, treat, and transfer the member, provided that such arrangement does not delay the provision of emergency services.

- 2.7.1.5 The CONTRACTOR shall not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergency in nature. If an emergency screening examination leads to a clinical determination by the examining provider that an actual emergency medical condition does not exist, then the determining factor for payment liability shall be whether the member had acute symptoms of sufficient severity at the time of presentation. In such cases, the CONTRACTOR shall review the presenting symptoms of the member and shall pay for all services involved in the screening examination where the presenting symptoms (including severe pain) were of sufficient severity to have warranted emergency attention under the prudent layperson standard regardless of final diagnosis.
- 2.7.1.6 When the member's PCP or the CONTRACTOR instructs the member to seek emergency services, the CONTRACTOR shall be responsible for payment for the medical screening examination and for other medically necessary emergency services, without regard to whether the member's condition meets the prudent layperson standard.
- 2.7.1.7 Once the member's condition is stabilized, the CONTRACTOR may require prior authorization for hospital admission or follow-up care.

2.7.2 Behavioral Health Services

2.7.2.1 General Provisions

- 2.7.2.1.1 The CONTRACTOR shall provide all behavioral health services as described in this Section, Section 2.6.1 and Attachment I.
- 2.7.2.1.2 The CONTRACTOR shall provide behavioral health services in accordance with best practice guidelines, rules and regulations, and policies and procedures issued by TDMHDD and approved by the Bureau of TennCare, including but not limited to "Managed Care Standards for Delivery of Behavioral Health Services".
- 2.7.2.1.3 The CONTRACTOR shall ensure that all members receiving behavioral health services from providers whose primary focus is to render behavioral health services have individualized treatment plans. Providers included in this requirement are:
 - 2.7.2.1.3.1 Community mental health agencies;
 - 2.7.2.1.3.2 Case management agencies;
 - 2.7.2.1.3.3 Psychiatric rehabilitation agencies;
 - 2.7.2.1.3.4 Psychiatric and substance abuse residential treatment facilities; and
 - 2.7.2.1.3.5 Psychiatric and substance abuse inpatient facilities.
- 2.7.2.1.4 Individualized treatment plans shall be completed within thirty (30) calendar days of the start date of service and updated every six (6) months, or more frequently as clinically appropriate. The treatment plans shall be developed, negotiated and agreed upon by the members and/or their support systems in face-to-face encounters and

shall be used to identify the treatment needs necessary to meet the members' stated goals. The duration and intensity of treatment shall promote the recovery and resilience of members and shall be documented in the treatment plans.

2.7.2.2 Psychiatric Inpatient Hospital Services

2.7.2.2.1 The CONTRACTOR shall ensure that all psychiatric inpatient hospitals serving children, youth, and adults separate members by age and render developmental age appropriate services.

2.7.2.2.2 The CONTRACTOR shall require that all psychiatric inpatient facilities are accredited by the Joint Commission and accept voluntary and involuntary admissions.

2.7.2.3 24-Hour Psychiatric Residential Treatment

2.7.2.3.1 The CONTRACTOR shall ensure that 24-hour psychiatric residential treatment facilities (RTFs) serving children, youth, and adults separate members by age and render developmental age appropriate services.

2.7.2.3.2 The CONTRACTOR shall ensure RTFs have the capacity to render short term crisis stabilization and long-term treatment and rehabilitation.

2.7.2.3.3 The CONTRACTOR shall ensure all RTFs meet local housing codes.

2.7.2.3.4 The CONTRACTOR shall ensure all RTFs are accredited by a State-recognized accreditation organization as required by 42 CFR 441.151.

2.7.2.4 Outpatient Mental Health Services

2.7.2.4.1 The CONTRACTOR shall ensure that outpatient mental health providers (including providers of intensive outpatient and providers of partial hospitalization services) serving children, youth and adults separate members by age and render developmental age appropriate services.

2.7.2.4.2 The CONTRACTOR shall ensure outpatient mental health providers are capable of rendering services both on and off site, as appropriate, depending on the services being rendered. On site services include, but are not limited to intensive outpatient services, partial hospitalization and many types of therapy. Off site services include but are not limited to intensive in home service for children and youth and home and community treatment for adults.

2.7.2.5 Inpatient, Residential & Outpatient Substance Abuse Services

2.7.2.5.1 The CONTRACTOR shall provide substance abuse treatment through inpatient, residential and outpatient services.

2.7.2.5.2 Detoxification services may be rendered as part of inpatient, residential or outpatient services, as clinically appropriate. The CONTRACTOR shall ensure all member detoxifications are supervised by Tennessee licensed physicians with a minimum daily re-evaluations by a physician or a registered nurse.

2.7.2.6 Mental Health Case Management

2.7.2.6.1 The CONTRACTOR shall provide mental health case management services only through providers licensed by the State to provide mental health outpatient services.

2.7.2.6.2 The CONTRACTOR shall provide mental health case management services according to mental health case management standards set by the State and outlined in Attachment I. Mental health case management services shall consist of two (2) levels of service as specified in Attachment I.

2.7.2.6.3 The CONTRACTOR shall require its providers to collect and submit individual encounter records for each mental health case management visit, regardless of the method of payment by the CONTRACTOR. The CONTRACTOR shall identify and separately report “level 1” and “level 2” mental health case management encounters outlined in Attachment I.

2.7.2.6.4 The CONTRACTOR shall require mental health case managers to involve the member, the member’s family or parent(s), or legally appointed representative, PCP, care coordinator for CHOICES members, and other agency representatives, if appropriate and authorized by the member as required, in mental health case management activities.

2.7.2.6.5 The CONTRACTOR shall ensure the continuing provision of mental health case management services to members under the conditions and time frames indicated below:

2.7.2.6.5.1 Members receiving mental health case management services at the start date of operations shall be maintained in mental health case management until such time as the member no longer qualifies on the basis of medical necessity or refuses treatment;

2.7.2.6.5.2 Members discharged from psychiatric inpatient hospitals and psychiatric residential treatment facilities shall be evaluated for mental health case management services and provided with appropriate behavioral health follow-up services; and

2.7.2.6.5.3 The CONTRACTOR shall review the cases of members referred by PCPs or otherwise identified to the CONTRACTOR as potentially in need of mental health case management services and shall contact and offer such services to all members who meet medical necessity criteria.

2.7.2.7 Psychiatric Rehabilitation Services

The CONTRACTOR shall provide psychiatric rehabilitation services in accordance with the requirements in Attachment I. As described in Attachment I, the covered array of services available under psychiatric rehabilitation are psychosocial rehabilitation, supported employment, peer support, illness management and recovery, and supported housing. An individual may receive one or more of these services and may receive different services from different providers.

2.7.2.8 Behavioral Health Crisis Services

2.7.2.8.1 *Entry into the Behavioral Health Crisis Services System*

2.7.2.8.1.1 The State shall maintain a statewide toll-free telephone number for entry into the behavioral health crisis system. This line shall be for any individual in the general population for the purposes of providing immediate phone intervention by trained crisis specialists and dispatch of mobile crisis teams.

2.7.2.8.1.2 The CONTRACTOR shall ensure that the crisis telephone line is linked to an appropriate crisis service team staffed by qualified crisis service providers in order to provide crisis intervention services to members.

2.7.2.8.1.3 As required in Section 2.11.5.3, the CONTRACTOR shall contract with specified crisis service teams for both adults and children as directed by the State.

2.7.2.8.1.4 The CONTRACTOR shall require the crisis service teams to provide telephone and walk-in triage screening services, telephone and face-to-face crisis intervention/assessment services, and follow-up telephone or face-to-face assessments to ensure the safety of the member until the member's treatment begins and/or the crisis is alleviated and/or stabilized.

2.7.2.8.1.5 Prior to admission to a psychiatric inpatient hospital on an involuntary basis, the CONTRACTOR shall ensure that the member has been evaluated by a crisis team. In addition, the CONTRACTOR shall ensure that Tennessee's statutory requirement for a face-to-face evaluation by a mandatory pre-screening agent (MPA), is conducted to assess eligibility for emergency involuntary admission to an RMHI (Regional Mental Health Institute) and determine whether all available less drastic alternatives services and supports are unsuitable.

2.7.2.8.2 *Behavioral Health Crisis Respite and Crisis Stabilization Services*

2.7.2.8.2.1 The CONTRACTOR shall ensure access to behavioral health crisis respite and crisis stabilization services.

2.7.2.8.2.2 Behavioral health crisis respite services provide immediate shelter to members with emotional/behavioral problems who are in need of emergency respite. The CONTRACTOR shall ensure that behavioral health crisis respite services are provided in a CONTRACTOR approved community location.

2.7.2.8.2.3 The CONTRACTOR shall ensure behavioral health crisis stabilization services are rendered at sites licensed by the State. These services are more intensive than regular behavioral health crisis services in that they require more secure environments, highly trained staff, and typically have longer stays.

2.7.2.8.3 The CONTRACTOR shall monitor behavioral health crisis services and report information to TENNCARE on a quarterly basis as described in Section 2.30.4.4.

2.7.2.9 Clinically Related Group (CRG) and Target Population Group (TPG) Assessments

2.7.2.9.1 The CONTRACTOR shall provide CRG/TPG assessments in response to requests from members or legally appointed representatives or, in the case of minors, the members' parents or legally appointed representatives, behavioral health providers, PCPs, or the State.

2.7.2.9.2 The CONTRACTOR shall complete CRG/TPG assessments within fourteen (14) calendar days of the requests. The CONTRACTOR shall not require prior authorization in order for a member to receive a CRG/TPG assessment.

2.7.2.9.3 The CONTRACTOR shall ensure that its contract providers are trained and that there is sufficient capacity to perform CRG/TPG assessments. The CONTRACTOR shall require providers to use the CRG/TPG assessment form(s) as appropriate, prescribed by and in accordance with the policies of the state. The CRG/TPG assessments shall be subject to review and prior written approval by the State.

2.7.2.9.4 The CONTRACTOR shall identify persons in need of CRG/TPG assessments. The CONTRACTOR shall use the CRG/TPG assessments to identify persons who are SPMI or SED for reporting and tracking purposes, in accordance with the definitions contained in Section 1.

2.7.2.9.5 The CONTRACTOR shall ensure that providers who perform CRG/TPG assessments have been trained and authorized by the State to perform CRG/TPG assessments. Certified trainers shall be responsible for providing rater training within their agencies.

2.7.2.9.6 The CONTRACTOR shall reject all CRG/TPG assessments completed by unapproved raters. The CONTRACTOR shall report on rejected assessments as required in Section 2.30.4.6.

2.7.2.9.7 The CONTRACTOR shall conduct audits of CRG/TPG assessments for accuracy and conformity to state policies and procedures. The CONTRACTOR shall audit all providers conducting these assessments on at least an annual basis. The methodology for these audits and the results of these audits shall be reported as required in Sections 2.30.4.7 and 2.30.4.8.

2.7.2.10 Judicial Services

2.7.2.10.1 The CONTRACTOR shall provide covered court ordered behavioral health services to its members pursuant to court order(s). The CONTRACTOR shall furnish these services in the same manner as services furnished to other members.

2.7.2.10.2 The CONTRACTOR shall provide for behavioral health services to its members in accordance with state law. Specific laws employed include the following:

2.7.2.10.2.1 Psychiatric treatment for persons found by the court to require judicial psychiatric hospitalization (TCA 33-6 part 4 and part 5). The CONTRACTOR may apply medical necessity criteria to the situation after twenty-four (24) hours of emergency services, unless there is a court order prohibiting release;

- 2.7.2.10.2.2 Judicial review of discharge for persons hospitalized by a circuit, criminal or juvenile court (TCA 33-6-708);
- 2.7.2.10.2.3 Access to and provision of mandatory outpatient psychiatric treatment and services to persons who are discharged from psychiatric hospitals after being hospitalized (TCA 33-6, Part 6);
- 2.7.2.10.2.4 Inpatient psychiatric examination for up to forty-eight (48) hours for persons whom the court has ordered to be detained for examination but who have been unwilling to be evaluated for hospital admission (TCA 33-3-607);
- 2.7.2.10.2.5 Voluntary psychiatric hospitalization for persons when determined to be medically necessary, subject to the availability of suitable accommodations (TCA 33-6, Part 2); and
- 2.7.2.10.2.6 Voluntary psychiatric hospitalization for persons with a severe impairment when determined to be medically necessary but who do not meet the criteria for emergency involuntary hospitalization, subject to the availability of suitable accommodations (TCA 33-6, Part 3).

2.7.2.11 Mandatory Outpatient Treatment

- 2.7.2.11.1 The CONTRACTOR shall provide mandatory outpatient treatment for individuals found not guilty by reason of insanity following a thirty (30) to sixty (60) calendar day inpatient evaluation. Treatment can be terminated only by the court pursuant to TCA 33-7-303(b).
- 2.7.2.11.2 The State will assume responsibility for all forensic services other than the mandatory outpatient treatment service identified in Section 2.7.2.11.1 (TCA 33-7-301(a), 33-7-301(b), 33-7-303(a) and 33-7-303(c)).

2.7.3 Self-Direction of Health Care Tasks

The CONTRACTOR shall, as specified in TennCare rules and regulations, offer CHOICES Group 2 and 3 members the option to direct and supervise a paid personal aide in the performance of health care tasks.

2.7.4 Health Education and Outreach

- 2.7.4.1 The CONTRACTOR shall develop programs and participate in activities to enhance the general health and well-being of members. Health education and outreach programs and activities may include the following:
 - 2.7.4.1.1 General physical, behavioral health and long-term care education classes;
 - 2.7.4.1.2 Mental illness awareness programs and education campaigns with special emphasis on events such as National Mental Health Month and National Depression Screening Day;
 - 2.7.4.1.3 Smoking cessation programs with targeted outreach for adolescents and pregnant women;

- 2.7.4.1.4 Nutrition counseling;
- 2.7.4.1.5 Early intervention and risk reduction strategies to avoid complications of disability and chronic illness;
- 2.7.4.1.6 Prevention and treatment of substance abuse;
- 2.7.4.1.7 Self care training, including self-examination;
- 2.7.4.1.8 Need for clear understanding of how to take medications and the importance of coordinating all medications;
- 2.7.4.1.9 Understanding the difference between emergent, urgent and routine health conditions;
- 2.7.4.1.10 Education for members on the significance of their role in their overall health and welfare and available resources;
- 2.7.4.1.11 Education for caregivers on the significance of their role in the overall health and welfare of the member and available resources;
- 2.7.4.1.12 Education for members and caregivers about identification and reporting of suspected abuse and neglect;
- 2.7.4.1.13 Telephone calls, mailings and home visits to current members for the sole purpose of educating current members about services offered by or available through the CONTRACTOR's MCO; and
- 2.7.4.1.14 General activities that benefit the entire community (e.g., health fairs and school activity sponsorships).
- 2.7.4.2 The CONTRACTOR shall ensure that all health education and outreach activities are prior approved in writing by TENNCARE (see Section 2.16.2 and Section 2.17.1).

2.7.5 Preventive Services

2.7.5.1 The CONTRACTOR shall provide preventive services which include, but are not limited to, initial and periodic evaluations, family planning services, prenatal care, laboratory services and immunizations in accordance with TennCare rules and regulations. These services shall be exempt from TennCare cost sharing responsibilities described in Section 2.6.7 of this Agreement (see TennCare rules and regulations for service codes).

2.7.5.2 Prenatal Care

2.7.5.2.1 The CONTRACTOR shall provide or arrange for the provision of medically necessary prenatal care to members beginning on the date of their enrollment in the CONTRACTOR's MCO. This requirement includes pregnant women who are presumptively eligible for TennCare, enrollees who become pregnant, as well as enrollees who are pregnant on the effective date of enrollment in the CONTRACTOR's

MCO. The requirement to provide or arrange for the provision of medically necessary prenatal care shall include assistance in making a timely appointment for a woman who is presumptively eligible and shall be provided as soon as the CONTRACTOR becomes aware of the enrollment. For a woman in her second or third trimester, the appointment shall occur as required in Section 2.11.4.2. In the event a member enrolling in the CONTRACTOR's MCO is receiving medically necessary prenatal care services the day before enrollment, the CONTRACTOR shall comply with the requirements in Sections 2.9.2.2 and 2.9.2.3 regarding prior authorization of prenatal care.

- 2.7.5.2.2 Failure of the CONTRACTOR to respond to a member's request for prenatal care by failing to identify a prenatal care provider to honor a request from a member, including a presumptively eligible member, (or from a PCP or patient advocate acting on behalf of a member) for a prenatal care appointment shall be considered a material breach of this Agreement.
- 2.7.5.2.3 The CONTRACTOR shall notify all contract providers that any unreasonable delay in providing care to a pregnant member seeking prenatal care shall be considered a material breach of the provider's agreement with the CONTRACTOR. Unreasonable delay in care for pregnant members shall mean failure of the prenatal care provider to meet the accessibility requirements required in Section 2.11.4 of this Agreement.

2.7.6 **TENNderCare**

2.7.6.1 General Provisions

- 2.7.6.1.1 The CONTRACTOR shall provide TENNderCare services to members under age twenty-one (21) in accordance with TennCare and federal requirements including TennCare rules and regulations, TennCare policies and procedures, 42 USC 1396a(a)(43), 1396d(a) and (r), 42 CFR Part 441, Subpart B, the Omnibus Budget Reconciliation Act of 1989, and the State Medicaid Manual. TENNderCare services means early and periodic screening, diagnosis and treatment of members under age twenty-one (21) to ascertain children's individual (or individualized/or on an individual basis) physical and mental defects, and providing treatment to correct or ameliorate, or prevent from worsening defects and physical and mental illnesses and conditions discovered by the screening services, regardless of whether the required service is a covered benefit as described in Section 2.6.1.
- 2.7.6.1.2 The CONTRACTOR shall use the name "TENNderCare" in describing or naming the State's EPSDT program or services. This requirement is applicable for all policies, procedures and other material, regardless of the format or media. No other names or labels shall be used.
- 2.7.6.1.3 The CONTRACTOR shall have written policies and procedures for the TENNderCare program that include coordinating services with child-serving agencies and providers, providing all medically necessary TENNderCare services to all eligible members under the age of twenty-one (21) regardless of whether the service is included in the Medicaid State Plan, and conducting outreach and education. The CONTRACTOR shall ensure the availability and accessibility of required health care resources and shall help members and their parents or legally appointed representatives use these resources effectively.

- 2.7.6.1.4 The CONTRACTOR shall be responsible for and comply with all provisions related to screening, vision, dental, and hearing services (including making arrangements for necessary follow-up if all components of a screen cannot be completed in a single visit).
- 2.7.6.1.5 The CONTRACTOR shall:
 - 2.7.6.1.5.1 Require that providers provide TENNderCare services;
 - 2.7.6.1.5.2 Require that providers make appropriate referrals and document said referrals in the member's medical record;
 - 2.7.6.1.5.3 Educate contract providers about proper coding and encourage them to submit the appropriate diagnosis codes identified by TENNCARE in conjunction with evaluation and management procedure codes for TENNderCare services;
 - 2.7.6.1.5.4 Educate contract providers about how to submit claims with appropriate codes and modifiers as described in standardized billing requirements (e.g., CPT, HCPCS, etc.) and require that they adjust billing methodology according to described components of said procedure codes/modifiers; and
 - 2.7.6.1.5.5 Monitor provider compliance with required TENNderCare activities including compliance with proper coding.
- 2.7.6.1.6 The CONTRACTOR shall require that its contract providers notify the CONTRACTOR in the event a screening reveals the need for other health care services and the provider is unable to make an appropriate referral for those services. Upon notification of the inability to make an appropriate referral, the CONTRACTOR shall secure an appropriate referral and contact the member to offer scheduling assistance and transportation for members lacking access to transportation. In the event the failed referral is for dental services, the CONTRACTOR shall coordinate with the DBM to arrange for services.
- 2.7.6.1.7 The CONTRACTOR shall not require prior authorization for periodic and interperiodic screens conducted by PCPs. The CONTRACTOR shall provide all medically necessary covered services regardless of whether the need for such services was identified by a provider who had received prior authorization from the CONTRACTOR or from a contract provider.
- 2.7.6.1.8 The CONTRACTOR shall have a tracking system to monitor each TENNderCare eligible member's receipt of the required screening, diagnosis, and treatment services. The tracking system shall have the ability to generate immediate reports on each member's TENNderCare status, reflecting all encounters reported more than sixty (60) days prior to the date of the report.
- 2.7.6.1.9 In the event that a member under sixteen (16) years of age is seeking behavioral health TENNderCare services and the member's parent(s), or legally appointed representative is unable to accompany the member to the examination, the CONTRACTOR shall require that its providers either contact the member's parent(s), or legally appointed representative to discuss the findings and inform the

family of any other necessary health care, diagnostic services, treatment or other measures recommended for the member or notify the MCO to contact the parent(s), or legally appointed representative with the results.

2.7.6.2 Member Education and Outreach

2.7.6.2.1 The CONTRACTOR shall be responsible for outreach activities and for informing members who are under the age of twenty-one (21), or their parent or legally appointed representative, of the availability of TENNderCare services. All TENNderCare member materials shall be submitted to TENNCARE for written approval prior to distribution in accordance with Section 2.17.1 and shall be made available in accordance with the requirements specified in Section 2.17.2.

2.7.6.2.2 The CONTRACTOR shall have a minimum of six (6) “outreach contacts” per member per calendar year in which it provides information about TENNderCare to members. The minimum “outreach contacts” include: one (1) member handbook as described in Section 2.17.4, four (4) quarterly member newsletters as described in Section 2.17.5, and one (1) reminder notice issued before a screening is due. The reminder notice shall include an offer of transportation and scheduling assistance.

2.7.6.2.2.1 If the CONTRACTOR’s TENNderCare screening rate is below ninety percent (90%), as determined in the most recent CMS 416 report, the CONTRACTOR shall conduct New Member Calls for all new members under the age of twenty-one (21) to inform them of TENNderCare services including assistance with appointment scheduling and transportation to appointments.

2.7.6.2.2.2 The CONTRACTOR shall have the ability to conduct TENNderCare outreach in formats appropriate to members who are blind, deaf, illiterate or have Limited English Proficiency. At least one of the 6 outreach attempts identified above shall advise members regarding how to request and/or access such assistance and/or information. The CONTRACTOR shall collaborate with agencies that have established procedures for working with special populations in order to develop effective outreach materials.

2.7.6.2.3 The CONTRACTOR shall have a mechanism for systematically notifying families when TENNderCare screens are due.

2.7.6.2.4 As part of its TENNderCare policies and procedures, the CONTRACTOR shall have a written process for following up with members who do not get their screenings timely. This process for follow up shall include provisions for documenting all outreach attempts and maintaining records of efforts made to reach out to members who have missed screening appointments or who have failed to receive regular check-ups. The CONTRACTOR shall make at least one (1) effort per quarter in excess of the six (6) “outreach contacts” to get the member in for a screening. The efforts, whether written or oral, shall be different each quarter. The CONTRACTOR is prohibited from simply sending the same letter four (4) times.

2.7.6.2.5 The CONTRACTOR shall have a process for determining if a member who is eligible for TENNderCare has used no services within a year and shall make two (2) reasonable attempts to re-notify such members about TENNderCare. The attempts must be different in format or message. One (1) of these attempts can be a referral to

DOH for a screen. (These two (2) attempts are in addition to the one (1) attempt per quarter mentioned in Section 2.7.6.2.4 above.)

- 2.7.6.2.6 The CONTRACTOR shall require that providers have a process for documenting services declined by a parent or legally appointed representative or mature competent child, specifying the particular service was declined. This process shall meet all requirements outlined in Section 5320.2.A of the State Medicaid Manual.
- 2.7.6.2.7 The CONTRACTOR shall make and document a minimum of two (2) reasonable attempts to find a member with one (1) of the two (2) attempts being made within thirty (30) days of receipt of mail returned as undeliverable and the second being made within ninety (90) days of receipt of mail returned as undeliverable. At least one (1) of these attempts shall be by phone.
- 2.7.6.2.8 The CONTRACTOR shall make available to members and families accurate lists of names and phone numbers of contract providers who are currently accepting TennCare members as described in Section 2.17.8 of this Agreement.
- 2.7.6.2.9 The CONTRACTOR shall target specific informing activities to pregnant women and families with newborns. Provided that the CONTRACTOR is aware of the pregnancy, the CONTRACTOR shall inform all pregnant women prior to the estimated delivery date about the availability of TENNderCare services for their children. The CONTRACTOR shall offer TENNderCare services for the child when it is born.
- 2.7.6.2.10 The CONTRACTOR shall provide member education and outreach in community settings. Outreach events shall be conducted in each Grand Region covered by this Agreement in accordance with the following specifications:
 - 2.7.6.2.10.1 Outreach events shall number a minimum of one hundred fifty (150) per year with no less than twenty-five (25) per region, per quarter.
 - 2.7.6.2.10.1.1 At least thirty percent (30%) shall be conducted in rural areas. Results of the CONTRACTOR's CMS 416 report and HEDIS report, as well as county demographics, shall be utilized in determining counties for targeted activities and in developing strategies for specific populations, particularly members who have limited English proficiency, low literacy levels, behavioral health needs, special health care needs or who are pregnant.
 - 2.7.6.2.10.2 The CONTRACTOR shall contact a minimum of twenty-five (25) state agencies or community-based organizations per quarter, to either educate them on services available through the CONTRACTOR or to develop outreach and educational initiatives. All of the agencies engaged shall be those who serve TennCare enrollees. Collaborative activities should include those designed to reach enrollees with limited English proficiency, low literacy levels, behavioral health needs, special health care needs or who are pregnant.
- 2.7.6.3 Screening
 - 2.7.6.3.1 The CONTRACTOR shall provide periodic comprehensive child health assessments meaning, "regularly scheduled examinations and evaluations of the general physical

and mental health, growth, development, and nutritional status of infants, children, and youth.”

- 2.7.6.3.2 At a minimum, these screens shall include periodic and interperiodic screens and be provided at intervals which meet reasonable standards of medical, behavioral and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care. The State has determined that “reasonable standards of medical and dental practice” are those standards set forth in the American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care for medical practice and American Academy of Pediatric Dentistry (AAPD) guidelines for dental practice. Tools used for screening shall be consistent with the screening guidelines recommended by the State which are available on the TennCare web site. These include, but are not limited to recommended screening guidelines for developmental/behavioral surveillance and screening, hearing screenings, and vision screenings.
- 2.7.6.3.3 The screens shall include, but not be limited to:
 - 2.7.6.3.3.1 Comprehensive health and developmental history (including assessment of physical and mental health development and dietary practices);
 - 2.7.6.3.3.2 Comprehensive unclothed physical examination, including measurements (the child’s growth shall be compared against that considered normal for the child’s age and gender);
 - 2.7.6.3.3.3 Appropriate immunizations scheduled according to the most current Advisory Committee on Immunization Practices (ACIP) schedule according to age and health history;
 - 2.7.6.3.3.4 Appropriate vision and hearing testing provided at intervals which meet reasonable standards of medical practice and at other intervals as medically necessary to determine the existence of suspected illness or condition;
 - 2.7.6.3.3.5 Appropriate laboratory tests (including lead toxicity screening appropriate for age and risk factors). All children are considered at risk and shall be screened for lead poisoning. All children shall receive a screening blood lead test at twelve (12) and twenty-four (24) months of age. Children between the ages of thirty-six (36) months and seventy-two (72) months of age shall receive a screening blood lead test if they have not been previously screened for lead poisoning. A blood lead test shall be used when screening Medicaid-eligible children. A blood lead test equal to or greater than ten (10) ug/dL obtained by capillary specimen (finger stick) shall be confirmed by using a venous blood sample; and
 - 2.7.6.3.3.6 Health education which includes anticipatory guidance based on the findings of all screening. Health education should include counseling to both members and members’ parents or to the legally appointed representative to assist in understanding what to expect in terms of the child’s development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.

- 2.7.6.3.4 The CONTRACTOR shall encourage providers to refer children to dentists for periodic dental screens beginning no later than three (3) years of age and earlier as needed (as early as six (6) to twelve (12) months in accordance with the American Academy of Pediatric Dentistry (AAPD) guidelines) and as otherwise appropriate.
- 2.7.6.3.5 The CONTRACTOR shall establish a procedure for PCPs or other providers completing TENNderCare screenings to refer TENNderCare eligible members requiring behavioral health services to appropriate providers.
- 2.7.6.4 Services
 - 2.7.6.4.1 Should screenings indicate a need, the CONTRACTOR shall provide all necessary health care, diagnostic services, treatment, and other measures described in 42 USC 1396d(a) (Section 1905(a) of the Social Security Act) to correct or ameliorate or prevent from worsening defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid State plan (see Section 2.7.6.4.8). This includes, but is not limited to, the services detailed below.
 - 2.7.6.4.2 The CONTRACTOR shall provide treatment for defects in vision and hearing, including eyeglasses and hearing aids.
 - 2.7.6.4.3 The CONTRACTOR shall coordinate with the DBM to ensure that TENNderCare eligible members receive dental care services furnished by direct referral to a dentist, at as early an age as necessary, and at intervals which meet reasonable standards of dental practice as determined by the State and at other intervals as medically necessary to determine the existence of a suspected illness or condition.
 - 2.7.6.4.4 The CONTRACTOR shall not require prior authorization or written PCP referral in order for a member to obtain a mental health or substance abuse assessment, whether the assessment is requested as follow-up to a TENNderCare screening or an interperiodic screening. This requirement shall not preclude the CONTRACTOR from requiring notification for a referral for an assessment. Furthermore, the CONTRACTOR shall establish a procedure for PCPs, or other providers, completing TENNderCare screenings, to refer members under the age of twenty-one (21) for a mental health or substance abuse assessment.
 - 2.7.6.4.5 For services not covered by Section 1905(a) of the Social Security Act, but found to be needed as a result of conditions disclosed during screening and diagnosis, the CONTRACTOR shall provide referral assistance as required by 42 CFR 441.61, including referral to providers and State health agencies.
 - 2.7.6.4.6 *Transportation Services*
 - 2.7.6.4.6.1 The CONTRACTOR shall provide transportation assistance for a child and for the child's escort or accompanying adult, including related travel expenses, cost of meals, and lodging en route to and from TennCare covered services. The requirement to provide the cost of meals shall not be interpreted to mean that a member (or the child's escort or accompanying adult) can request meals while in transport to and from care. Reimbursement for meals and lodging shall only be

provided when transportation for a TennCare covered service cannot be completed in one (1) day and would require an overnight stay.

2.7.6.4.6.2 The CONTRACTOR shall offer transportation and scheduling assistance to all members under age twenty-one (21) who do not have access to transportation in order to access covered services. This may be accomplished through various means of communication to members, including but not limited to, member handbooks, TENNderCare outreach notifications, etc.

2.7.6.4.7 *Services for Elevated Blood Lead Levels*

2.7.6.4.7.1 The CONTRACTOR shall provide follow up for elevated blood lead levels in accordance with the State Medicaid Manual, Part 5. The Manual currently says that children with blood lead levels equal to or greater than ten (10) ug/dL should be followed according to CDC guidelines. These guidelines include follow up blood tests and investigations to determine the source of lead, when indicated.

2.7.6.4.7.2 The CONTRACTOR shall provide for any follow up service within the scope of the federal Medicaid statute, including diagnostic or treatment services determined to be medically necessary when elevated blood lead levels are identified in children. Such services would include both MCO case management services and a one (1) time investigation to determine the source of lead.

2.7.6.4.7.3 The CONTRACTOR is responsible for the primary environmental lead investigation—commonly called a “lead inspection”—for children when elevated blood levels suggest a need for such an investigation.

2.7.6.4.7.4 If the lead inspection does not reveal the presence of lead paint in the home, there may be a need for other testing, such as risk assessments involving water and soil sampling or inspections of sites other than the primary residence if the child spends a substantial amount of time in another location. The CONTRACTOR is not responsible for either the risk assessments or the lead inspection at the secondary site. However, the CONTRACTOR shall contact the DOH when these services are indicated as this agency is responsible for these services.

2.7.6.4.7.5 CONTRACTOR reimbursement for the primary environmental investigations is limited to the items specified in Part 5 of the State Medicaid Manual. These items include the health professional’s time and activities during the on-site investigation of the child’s primary residence. They do not include testing of environmental substances such as water, paint, or soil.

2.7.6.4.8 *Services Chart*

Pursuant to federal and state requirements, TennCare enrollees under the age of 21 are eligible for all services listed in Section 1905(a) of the Social Security Act. These services, and the entity responsible for providing them to TennCare enrollees under the age of 21, are listed below. Notwithstanding any other provision of this Agreement, the CONTRACTOR shall provide all services for which “MCO” is identified as the responsible entity to members under the age of 21. All services, other than TENNderCare screens and interperiodic screens, must be medically necessary in order to be covered by the CONTRACTOR. The CONTRACTOR shall provide all medically necessary TENNderCare covered services regardless of whether or not the need for such services was identified by a provider whose services had received prior authorization from the CONTRACTOR or by a contract provider.

Services Listed in Social Security Act Section 1905(a)	Responsible Entity in Tennessee	Comments
(1) Inpatient hospital services (other than services in an institution for mental diseases)	MCO	
(2)(A) Outpatient hospital services	MCO	
(2)(B) Rural health clinic services (RHCs)	MCO	MCOs are not required to contract with RHCs if the services are available through other contract providers.
(2)(C) Federally-qualified health center services (FQHCs)	MCO	MCOs are not required to contract with FQHCs if they can demonstrate adequate provider capacity without them.
(3) Other laboratory and X-ray services	MCO	
(4)(A) Nursing facility services for individuals age 21 and older		Not applicable for TENNderCare
(4)(B) EPSDT services	MCO for physical health and behavioral health services; DBM for dental services except as described in Section 2.6.1.3; PBM for pharmacy services as described except as in Section 2.6.1.3	

Services Listed in Social Security Act Section 1905(a)	Responsible Entity in Tennessee	Comments
(4)(C) Family planning services and supplies	MCO; PBM for pharmacy services except as described in Section 2.6.1.3	
(5)(A) Physicians' services furnished by a physician, whether furnished in the office, the patient's home, a hospital, or a nursing facility	MCO	
(5)(B) Medical and surgical services furnished by a dentist	DBM except as described in Section 2.6.1.3	
(6) Medical care, or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law	MCO	See Item (13)
(7) Home health care services	MCO	
(8) Private duty nursing services	MCO	
(9) Clinic services	MCO	
(10) Dental services	DBM except as described in Section 2.6.1.3	
(11) Physical therapy and related services	MCO	
(12) Prescribed drugs, dentures, and prosthetic devices, and eyeglasses	MCO; PBM for pharmacy services except as described in Section 2.6.1.3; DBM for dentures	
(13) Other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts within	MCO for physical health and behavioral health services; DBM for dental services except as described in Section 2.6.1.3; PBM for pharmacy services except as described in Section 2.6.1.3	The following are considered practitioners of the healing arts in Tennessee law: ¹ <ul style="list-style-type: none"> • Alcohol and drug abuse counselor • Athletic trainer • Audiologist • Certified

¹ This list was provided by the Tennessee Department of Health.

Services Listed in Social Security Act Section 1905(a)	Responsible Entity in Tennessee	Comments
<p>the scope of their practice under state law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level</p>		<ul style="list-style-type: none"> acupuncturist • Certified master social worker • Certified nurse practitioner • Certified professional counselor • Certified psychological assistant • Chiropractic physician • Chiropractic therapy assistant • Clinical pastoral therapist • Dentist • Dental assistant • Dental hygienist • Dietitian/nutritionist • Dispensing optician • Electrologist • Emergency medical personnel • First responder • Hearing instrument specialist • Laboratory personnel • Licensed clinical perfusionist • Licensed clinical social worker • Licensed practical nurse • Licensed professional counselor • Marital and family therapist, certified • Marital and family therapist, licensed • Massage therapist • Medical doctor • Medical doctor

Services Listed in Social Security Act Section 1905(a)	Responsible Entity in Tennessee	Comments
		<p>(special training)</p> <ul style="list-style-type: none"> • Midwives and nurse midwives • Nurse aide • Occupational therapist • Occupational therapy assistant • Optometrist • Osteopathic physician • Pharmacist • Physical therapist • Physical therapist assistant • Physician assistant • Podiatrist • Psychological examiner • Psychologist • Registered nurse • Registered certified reflexologist • Respiratory care assistant • Respiratory care technician • Respiratory care therapist • Senior psychological examiner • Speech pathologist • Speech pathology aide • X-ray op in chiropractic physician's office • X-ray op in MD office • X-ray op in osteopathic office • X-ray op in podiatrist's office

Services Listed in Social Security Act Section 1905(a)	Responsible Entity in Tennessee	Comments
(14) Inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases		Not applicable for TENNderCare
(15) Services in an intermediate care facility for the mentally retarded	TENNCARE	
(16) Inpatient psychiatric services for individuals under age 21	MCO	
(17) Services furnished by a nurse-midwife	MCO	The MCOs are not required to contract with nurse-midwives if the services are available through other contract providers.
(18) Hospice care	MCO	
(19) Case management services	MCO	
(20) Respiratory care services	MCO	
(21) Services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner	MCO	The MCOs are not required to contract with PNP's or CFNP's if the services are available through other contract providers.
(22) Home and community care for functionally disabled elderly individuals		Not applicable for TENNderCare
(23) Community supported living arrangements services		Not applicable for TENNderCare
(24) Personal care services	MCO	
(25) Primary care case management services		Not applicable
(26) Services furnished under a PACE program		Not applicable for TENNderCare

Services Listed in Social Security Act Section 1905(a)	Responsible Entity in Tennessee	Comments
(27) Any other medical care, and any other type of remedial care recognized under state law.	MCO for physical and behavioral health services; DBM for dental services except as described in Section 2.6.1.3; PBM for pharmacy services except as described in Section 2.6.1.3	See Item (13)

2.7.6.4.8.1 **Note 1:** “Targeted case management services,” which are listed under Section 1915(g)(1), are **not TENNderCare services** except to the extent that the definition in Section 1915(g)(2) is used with Item (19) above.

2.7.6.4.8.2 **Note 2:** “Psychiatric residential treatment facility” is not listed in Social Security Act Section 1905(a). It is, however, defined in 42 CFR 483.352 as “a facility other than a hospital, that provides psychiatric services, as described in subpart D of part 441 of this chapter, to individuals under age twenty-one (21), in an inpatient setting.”

2.7.6.4.8.3 **Note 3:** “Rehabilitative” services are differentiated from “habilitative” services in federal law. “Rehabilitative” services, which are TENNderCare services, are defined in 42 CFR 440.130(d) as services designed “for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level.” “Habilitative” services, which are **not TENNderCare services**, are defined in Section 1915(c)(5) as services designed “to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings.”

2.7.6.4.8.4 **Note 4:** Certain services are covered under a Home and Community Based waiver but are **not TENNderCare services** because they are not listed in the Social Security Act Section 1905(a). These services include habilitation, prevocational, supported employment services, homemaker services and respite services. (See Section 1915(c)(4).)

2.7.6.4.8.5 **Note 5:** Certain services are not coverable even under a Home and Community Based waiver and are **not TENNderCare services**. These services include room and board, and special education and related services which are otherwise available through a Local Education Agency. (See Section 1915(c)(5).)

2.7.6.5 Children with Special Health Care Needs

Children with special health care needs are those children who are in the custody of DCS. As provided in Section 2.4.4.4, TennCare enrollees who are in the custody of DCS will be enrolled in TennCare Select.

2.7.7 **Advance Directives**

- 2.7.7.1 The CONTRACTOR shall maintain written policies and procedures for advance directives that comply with all federal and state requirements concerning advance directives, including but not limited to 42 CFR 422.128, 438.6 and 489 Subpart I; TCA 32-11-101 *et seq.*, 34-6-201 *et seq.*, and 68-11-201 through 68-11-224; and any requirements as stipulated by the member. Any written information provided by the CONTRACTOR shall reflect changes in state law by the effective date specified in the law, if not specified then within thirty (30) calendar days after the effective date of the change.
- 2.7.7.2 The CONTRACTOR shall provide its policies and procedures to all members eighteen (18) years of age and older and shall educate members about their ability to direct their care using this mechanism and shall specifically designate which staff members and/or contract providers are responsible for providing this education.
- 2.7.7.3 The CONTRACTOR shall educate its staff about its policies and procedures on advance directives, situations in which advance directives may be of benefit to members, and their responsibility to educate members about this tool and assist them to make use of it.
- 2.7.7.4 The CONTRACTOR, for behavioral health services, shall provide its policies and procedures to all members sixteen (16) years of age and older and shall educate members about their ability to direct their care using advance directives including the use of Declarations for Mental Health Treatment under TCA Title 33, Chapter 6, Part 10. The CONTRACTOR shall specifically designate staff members and/or providers responsible for providing this education.
- 2.7.7.5 For CHOICES members, the care coordinator shall educate members about their ability to use advance directives during the face-to-face intake visit for current members or the face-to-face visit with new members, as applicable.

2.7.8 **Sterilizations, Hysterectomies and Abortions**

- 2.7.8.1 The CONTRACTOR shall cover sterilizations, hysterectomies and abortions pursuant to applicable federal and state law. The CONTRACTOR shall ensure that when coverage requires the completion of a specific form, the form is properly completed as described in the instructions with the original form maintained in the member's medical records and a copy submitted to the CONTRACTOR for retention in the event of audit.
- 2.7.8.2 Sterilizations
- Sterilization shall mean any medical procedure, treatment or operation done for the purpose of rendering an individual permanently incapable of reproducing. The CONTRACTOR shall cover sterilizations only if the following requirements are met:
- 2.7.8.2.1 At least thirty (30) calendar days, but not more than one hundred eighty (180) calendar days, have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery. A member may consent to be sterilized at the time of a premature delivery or

emergency abdominal surgery if at least seventy-two (72) hours have passed since the member gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least thirty (30) calendar days before the expected date of delivery;

- 2.7.8.2.2 The member is at least twenty-one (21) years old at the time consent is obtained;
- 2.7.8.2.3 The member is mentally competent;
- 2.7.8.2.4 The member is not institutionalized (i.e., not involuntarily confined or detained under a civil or criminal status in a correctional or rehabilitative facility or confined in a mental hospital or other facility for the care and treatment of mental illness, whether voluntarily or involuntarily committed); and
- 2.7.8.2.5 The member has voluntarily given informed consent on the approved “STERILIZATION CONSENT FORM” which is available on TENNCARE’s web site. The form shall be available in English and Spanish, and the CONTRACTOR shall provide assistance in completing the form when an alternative form of communication is necessary.

2.7.8.3 Hysterectomies

2.7.8.3.1 Hysterectomy shall mean a medical procedure or operation for the purpose of removing the uterus. The CONTRACTOR shall cover hysterectomies only if the following requirements are met:

- 2.7.8.3.1.1 The hysterectomy is medically necessary;
- 2.7.8.3.1.2 The member or her authorized representative, if any, has been informed orally and in writing that the hysterectomy will render the member permanently incapable of reproducing; and
- 2.7.8.3.1.3 The member or her authorized representative, if any, has signed and dated an “ACKNOWLEDGMENT OF HYSTERECTOMY INFORMATION” form which is available on the Bureau of TennCare’s web site, prior to the hysterectomy. Informed consent shall be obtained regardless of diagnosis or age in accordance with federal requirements. The form shall be available in English and Spanish, and assistance shall be provided in completing the form when an alternative form of communication is necessary. Refer to “ACKNOWLEDGMENT OF HYSTERECTOMY INFORMATION” form and instructions for additional guidance and exceptions.

2.7.8.3.2 The CONTRACTOR shall not cover hysterectomies under the following circumstances:

- 2.7.8.3.2.1 If it is performed solely for the purpose of rendering an individual permanently incapable of reproducing;
- 2.7.8.3.2.2 If there is more than one purpose for performing the hysterectomy, but the primary purpose is to render the individual permanently incapable of reproducing; or

2.7.8.3.2.3 It is performed for the purpose of cancer prophylaxis.

2.7.8.4 Abortions

2.7.8.4.1 The CONTRACTOR shall cover abortions and services associated with the abortion procedure only if the pregnancy is the result of an act of rape or incest; or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

2.7.8.4.2 The CONTRACTOR shall ensure that a “CERTIFICATION OF MEDICAL NECESSITY FOR ABORTION” form, which is available on TENNCARE’s web site, is completed. The form shall be available in English and Spanish, and assistance shall be provided in completing the form when an alternative form of communication is necessary.

11. Section 2.8 shall be amended by deleting Section 2.8 in its entirety and replacing it with the following and renumbering all references thereto:

2.8 DISEASE MANAGEMENT

2.8.1 General

2.8.1.1 The CONTRACTOR shall establish and operate a disease management (DM) program for each of the following conditions:

2.8.1.1.1 Maternity care management, in particular high-risk obstetrics;

2.8.1.1.2 Diabetes;

2.8.1.1.3 Congestive heart failure;

2.8.1.1.4 Asthma;

2.8.1.1.5 Coronary artery disease;

2.8.1.1.6 Chronic-obstructive pulmonary disease;

2.8.1.1.7 Obesity as referenced in Section 2.8.8;

2.8.1.1.8 Bipolar disorder;

2.8.1.1.9 Major depression; and

2.8.1.1.10 Schizophrenia.

- 2.8.1.2 Each DM program shall utilize evidence-based clinical practice guidelines (hereafter referred to as the guidelines) that have been formally adopted by the CONTRACTOR's Quality Management/Quality Improvement (QM/QI) committee or other clinical committee and patient empowerment strategies to support the provider-patient relationship and the plan of care. For the conditions listed in 2.8.1.1.1 through 2.8.1.1.10, the guidelines shall include a requirement to conduct a mental health and substance abuse screening. The DM programs for bipolar disorder, major depression, and schizophrenia shall include the use of the evidence-based practice for co-occurring disorders.
- 2.8.1.3 The DM programs shall emphasize the prevention of exacerbation and complications of the conditions as evidenced by decreases in emergency room utilization and inpatient hospitalization and/or improvements in condition-specific health status indicators.
- 2.8.1.4 The CONTRACTOR shall develop and maintain DM program descriptions. These program descriptions shall include, for each of the conditions listed above, the following:
 - 2.8.1.4.1 The definition of the target population;
 - 2.8.1.4.2 Member identification strategies, which shall not exclude CHOICES members, including dual eligible CHOICES members;
 - 2.8.1.4.3 The guidelines as referenced in Section 2.15.4;
 - 2.8.1.4.4 Written description of the stratification levels for each of the conditions, including member criteria and associated interventions;
 - 2.8.1.4.5 Program content;
 - 2.8.1.4.6 Targeted methods for informing and educating members, which, for CHOICES members, include but shall not be limited to mailing educational materials;
 - 2.8.1.4.7 Methods for informing and educating providers; and
 - 2.8.1.4.8 Program evaluation.
- 2.8.1.5 As part of its DM program descriptions, the CONTRACTOR shall also address how the DM programs will coordinate with MCO case management activities, in particular for members who would benefit from both.
- 2.8.1.6 The CONTRACTOR's DM and care coordination program description shall address how the CONTRACTOR shall ensure that upon enrollment into CHOICES, disease management activities are integrated with CHOICES care coordination processes and functions, and that the member's assigned care coordinator has primary responsibility for coordination of all the member's physical health, behavioral health, and long-term care services, including appropriate management of conditions specified in 2.8.1.1. If a CHOICES member has one or more of the conditions specified in Section 2.8.1.1, the member's care coordinator may use the CONTRACTOR's applicable DM tools and resources, including staff with specialized training, to help manage the member's

condition and shall integrate the use of these DM tools and resources with care coordination. DM staff shall supplement but not supplant the role and responsibilities of the member's care coordinator/care coordination team. The CONTRACTOR's program description shall also include at a minimum how the CONTRACTOR will address the following for CHOICES members:

- 2.8.1.6.1 Notify the member's care coordinator of the member's participation in a DM program;
- 2.8.1.6.2 Provide to the member's care coordinator information about the member collected through the DM program;
- 2.8.1.6.3 Provide to the care coordinator any educational materials given to the member through the DM program;
- 2.8.1.6.4 Ensure that the care coordinator reviews the information noted in Section 2.8.1.6.3 above verbally with the member and with the member's caregiver and/or representative (as applicable) and coordinates any necessary follow-up that may be needed regarding the DM program such as scheduling screenings or appointments;
- 2.8.1.6.5 Ensure that the care coordinator integrates into the member's plan of care aspects of the DM program that would help to better manage the member's condition; and
- 2.8.1.6.6 Ensure that the member's care coordinator shall be responsible for coordinating with the member's providers regarding the development and implementation of an individualized treatment plan which shall be integrated into the member's plan of care and which shall include monitoring the member's condition, helping to ensure compliance with treatment protocols, and to the extent appropriate, lifestyle changes which will help to better ensure management of the member's condition (see Section 2.9.6 of this Agreement).

2.8.2 Member Identification Strategies

- 2.8.2.1 The CONTRACTOR shall have a systematic method of identifying and enrolling eligible members in each DM program, including CHOICES members, through the same processes used for identification of non-CHOICES members and the CHOICES care coordination process.
- 2.8.2.2 The CONTRACTOR shall operate its disease management programs using an "opt out" methodology, meaning that disease management services shall be provided to eligible members unless they specifically ask to be excluded.

2.8.3 **Stratification**

As part of the DM programs, the CONTRACTOR shall classify eligible members into stratification levels according to condition severity or other clinical or member-provided information which, for members enrolled in the CHOICES program shall also include stratification by the type of setting in which long-term care services are delivered, i.e., nursing facility, community-based residential alternative (for members in CHOICES Group 2), or home-based (for members in CHOICES Group 2 or 3). The DM programs shall tailor the program content and education activities for each stratification level. For CHOICES members, this shall include targeted interventions based on the setting in which the member resides.

2.8.4 **Program Content**

Each DM program shall include the development of treatment plans, as described in NCQA Disease Management program content, that serve as the outline for all of the activities and interventions in the program. At a minimum the activities and interventions associated with the treatment plan shall address condition monitoring, patient adherence to the treatment plan, consideration of other co-morbidities, and condition-related lifestyle issues. For CHOICES members, appropriate elements of the treatment plan shall be individualized and integrated into the member's plan of care to facilitate better management of the member's condition.

2.8.5 **Informing and Educating Members**

The DM programs shall educate members and/or their caregivers regarding their particular condition(s) and needs. This information shall be provided upon enrollment in the DM program. The DM programs shall educate members to increase their understanding of their condition(s), the factors that impact their health status (e.g., diet and nutrition, lifestyle, exercise, medication compliance), and to empower members to be more effective in self-care and management of their health so they:

- 2.8.5.1 Are proactive and effective partners in their care;
- 2.8.5.2 Understand the appropriate use of resources needed for their care;
- 2.8.5.3 Identify precipitating factors and appropriate responses before they require more acute intervention; and
- 2.8.5.4 Are compliant and cooperative with the recommended treatment plan.

2.8.6 **Informing and Educating Providers**

As part of the DM programs, the CONTRACTOR shall educate providers regarding the guidelines and shall distribute the guidelines to providers who are likely to treat enrollees with the DM conditions. This includes, but is not limited to, PCPs and specialists involved in treating that particular condition. The CONTRACTOR shall also provide each PCP with a list of their patients enrolled in each DM program upon the member's initial enrollment and at least annually thereafter. The CONTRACTOR shall provide specific information to the provider concerning how the program(s) works. The DM's provider education shall be designed to increase the providers' adherence to the guidelines in order to improve the members' conditions.

2.8.7 Program Evaluation (Satisfaction and Effectiveness)

- 2.8.7.1 The CONTRACTOR shall evaluate member satisfaction with the DM services (as described by NCQA) by systematically analyzing feedback from members and analyzing member complaints and inquiries at least annually. The feedback on satisfaction shall be specific to DM programs.
- 2.8.7.1.1 A written summary, of member satisfaction with the DM program, shall be included in the annual DM report.
- 2.8.7.2 The CONTRACTOR shall establish measurable benchmarks and goals for each DM program and shall evaluate the programs using these benchmarks and goals. The calculations for the benchmarks and goals should include non-CHOICES members only. These benchmarks and goals shall include:
 - 2.8.7.2.1 The rate of emergency department utilization and inpatient hospitalization;
 - 2.8.7.2.2 Neonatal Intensive Care Unit (NICU) days for births associated with members enrolled in the maternity care management program;
 - 2.8.7.2.3 Appropriate HEDIS measures;
 - 2.8.7.2.4 The passive participation rates (as defined by NCQA) and the number of individuals participating in each level of each of the DM programs;
 - 2.8.7.2.5 Member adherence to treatment plans; and
 - 2.8.7.2.6 Provider adherence to the guidelines.
- 2.8.7.3 The CONTRACTOR shall report on DM activities as required in Section 2.30.5.

2.8.8 Obesity Disease Management

In addition to the aforementioned DM program requirements, the CONTRACTOR shall have a DM program for obesity that is provided as a cost effective alternative service (see Section 2.6.5). The CONTRACTOR may fulfill this requirement by entering into a provider agreement with Weight Watchers and then referring/authorizing eligible obese and overweight members to participate in a Weight Watchers program. If the CONTRACTOR identifies another weight management program as the cost effective alternative service, the CONTRACTOR shall include a narrative of the program (including target population and description of services) as part of its quarterly disease management report (see Section 2.30.5.1) applicable to the quarter in which the program was implemented.

12. Section 2.9 shall be amended by deleting Section 2.9 in its entirety and replacing it with the following and renumbering all references thereto:

2.9 SERVICE COORDINATION

2.9.1 General

2.9.1.1 The CONTRACTOR shall be responsible for the management, coordination, and continuity of care for all its TennCare members and shall develop and maintain policies and procedures to address this responsibility. For CHOICES members, these policies and procedures shall specify the role of the care coordinator/care coordination team in conducting these functions (see Section 2.9.6).

2.9.1.2 The CONTRACTOR shall:

2.9.1.2.1 Coordinate care for children in DCS custody;

2.9.1.2.2 Coordinate care among PCPs, specialists, behavioral health providers, and long-term care providers;

2.9.1.2.3 Perform reasonable preventive health case management services, have mechanisms to assess the quality and appropriateness of services furnished, and provide appropriate referral and scheduling assistance;

2.9.1.2.4 Monitor members with ongoing medical or behavioral health conditions;

2.9.1.2.5 Identify members using emergency department services inappropriately to assist in scheduling follow-up care with PCPs and/or appropriate specialists to improve continuity of care and establish a medical home;

2.9.1.2.6 Maintain and operate a formalized hospital and/or institutional discharge planning program;

2.9.1.2.7 Coordinate hospital and/or institutional discharge planning that includes post-discharge care, as appropriate;

2.9.1.2.8 Maintain an internal tracking system that identifies the current preventive services screening status and pending preventive services screening due dates for each member; and

2.9.1.2.9 Authorize services provided by non-contract providers, as required in this Agreement (see, e.g., Section 2.13).

2.9.2 Transition of New Members

2.9.2.1 In the event an enrollee entering the CONTRACTOR's MCO, either as a new TennCare enrollee or transferring from another MCO, is receiving medically necessary covered services in addition to or other than prenatal services (see below for enrollees receiving only prenatal services) the day before enrollment, the CONTRACTOR shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether

such services are being provided by contract or non-contract providers. Except as specified in this Section 2.9.2 or in Sections 2.9.3 or 2.9.6, this requirement shall not apply to long-term care services.

- 2.9.2.1.1 For medically necessary covered services, other than long-term care services, being provided by a non-contract provider, the CONTRACTOR shall provide continuation of such services for up to ninety (90) calendar days or until the member may be reasonably transferred without disruption to a contract provider, whichever is less. The CONTRACTOR may require prior authorization for continuation of services beyond thirty (30) calendar days; however, the CONTRACTOR is prohibited from denying authorization solely on the basis that the provider is a non-contract provider.
- 2.9.2.1.2 For medically necessary covered services, other than long-term care services, being provided by a contract provider, the CONTRACTOR shall provide continuation of such services from that provider but may require prior authorization for continuation of such services from that provider beyond thirty (30) calendar days. The CONTRACTOR may initiate a provider change only as otherwise specified in this Agreement.
- 2.9.2.1.3 For medically necessary covered long-term care services for CHOICES members who are new to both TennCare and CHOICES, the CONTRACTOR shall provide long-term care services as specified in Sections 2.9.6.2.4 and 2.9.6.2.5.
- 2.9.2.1.4 For covered long-term care services for CHOICES members who are transferring from another MCO, the CONTRACTOR shall be responsible for continuing to provide covered long-term care services, including both nursing facility services and, for CHOICES Group 2 and 3 member, HCBS authorized by the transferring MCO, without regard to whether such services are being provided by contract or non-contract providers. Unless and until the CONTRACTOR has been directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, only members in CHOICES Group 1 will be enrolled with the CONTRACTOR. Therefore, unless and until directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the requirements in this Section 2.9.2.1.4 applicable only to CHOICES Group 2 and/or 3 will not apply. When directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the CONTRACTOR shall, as directed by TENNCARE, comply with all of the requirements in Section 2.9.2.1.4.
 - 2.9.2.1.4.1 For a member in CHOICES Group 2 or 3, the CONTRACTOR shall continue HCBS authorized by the transferring MCO for a minimum of thirty (30) days after the member's enrollment and thereafter shall not reduce these services unless a care coordinator has conducted a comprehensive needs assessment and developed a plan of care, and the CONTRACTOR has authorized and initiated HCBS in accordance with the member's new plan of care. If a member in CHOICES Group 2 or 3 is receiving short-term nursing facility care, the CONTRACTOR shall continue to provide nursing facility services to the member in accordance with the level of nursing facility services (Level I or Level II) approved by TENNCARE (see Section 2.14.1.12). For a member in CHOICES Group 1, the CONTRACTOR shall provide nursing facility services to the member in accordance with the level of nursing facility services (Level I or Level II) approved by TENNCARE (see Section 2.14.1.12); however, the

member may be transitioned to the community in accordance with Section 2.9.6.8 of this Agreement.

- 2.9.2.1.4.2 For a member in CHOICES Group 2 or 3, within thirty (30) days of notice of the member's enrollment with the CONTRACTOR, a care coordinator shall conduct a face-to-face visit (see Section 2.9.6.2.5), including a comprehensive needs assessment (see Section 2.9.6.5), and develop a plan of care (see Section 2.9.6.6), and the CONTRACTOR shall authorize and initiate HCBS in accordance with the new plan of care (see Section 2.9.6.2.5). If a member in CHOICES Group 2 or 3 is receiving short-term nursing facility care on the date of enrollment with the CONTRACTOR, a care coordinator shall complete a face-to-face visit prior to the expiration date of the level of nursing facility services approved by TENNCARE, but no later than thirty (30) days after enrollment to determine appropriate needs assessment and care planning activities (see Section 2.9.6.2.5 for members who will be discharged from the nursing facility and remain in CHOICES Group 2 or 3 and Section 2.9.6.2.4 for members who will remain in the nursing facility and be enrolled in CHOICES Group 1). If the expiration date for the level of nursing facility services approved by TENNCARE occurs prior to thirty (30) days after enrollment, and the CONTRACTOR is unable to conduct the face-to-face visit prior to the expiration date, the CONTRACTOR shall be responsible for facilitating discharge to the community or enrollment in CHOICES Group 1, whichever is appropriate.
- 2.9.2.1.4.3 If at any time before conducting a comprehensive needs assessment for a member in CHOICES Group 2 or 3 the CONTRACTOR becomes aware of an increase in the member's needs, a care coordinator shall immediately conduct a comprehensive needs assessment and update the member's plan of care, and the CONTRACTOR shall initiate the change in services within ten (10) days of becoming aware of the increase in the member's needs.
- 2.9.2.1.4.4 For a member in CHOICES Group 1 who, at the time of enrollment with the CONTRACTOR, has resided in a nursing facility for less than ninety (90) days, a care coordinator shall conduct a face-to-face in-facility visit within thirty (30) days of the member's enrollment with the CONTRACTOR and conduct a needs assessment as determined necessary by the CONTRACTOR (see Section 2.9.6.5). For a member in CHOICES Group 1 who, at the time of enrollment with the CONTRACTOR, has resided in a nursing facility for ninety (90) days or more, a care coordinator shall conduct a face-to-face in-facility visit within sixty (60) days of the member's enrollment with the CONTRACTOR and conduct a needs assessment as determined necessary by the CONTRACTOR (see Section 2.9.6.5).
- 2.9.2.1.4.5 The CONTRACTOR shall facilitate a seamless transition to new services and/or providers, as applicable, in the plan of care developed by the CONTRACTOR without any disruption in services.
- 2.9.2.1.4.6 The CONTRACTOR shall not:
 - 2.9.2.1.4.6.1 Transition nursing facility residents or CHOICES Group 2 members who are residents of community-based residential alternatives to another facility unless (1) the member or his/her representative specifically requests to transition, which

shall be documented in the member's file, (2) the member or his/her representative provides written consent to transition based on quality or other concerns raised by the CONTRACTOR, which shall not include the nursing facility's rate of reimbursement; or (3) the facility where the member is residing is not a contract provider; if the community-based residential facility where the CHOICES Group 2 member is currently residing is not a contract provider, the CONTRACTOR shall provide continuation of services in such facility for at least thirty (30) days, which shall be extended as necessary to ensure continuity of care pending the facility's contracting with the CONTRACTOR or the member's transition to a contract facility; if the member is transitioned to a contract facility, the CONTRACTOR shall facilitate a seamless transition to the new facility; if the nursing facility where the member is currently residing is a non-contract provider, the CONTRACTOR shall (a) authorize continuation of the services pending enrollment of the facility as a contract provider (except a facility excluded for a 2-year period when the facility has withdrawn from Medicaid participation); (b) authorize continuation of the services pending facilitation of the member's transition to a contract facility, subject to the member's agreement with such transition; or (c) may continue to reimburse services from the non-contract nursing facility in accordance with TennCare rules and regulations;

- 2.9.2.1.4.6.2 Transition Group 1 members to HCBS unless the member chooses to receive HCBS as an alternative to nursing facility care and is enrolled in CHOICES Group 2 (see Section 2.9.6.8 for requirements regarding nursing facility to community transition);
- 2.9.2.1.4.6.3 Admit a member in CHOICES Group 2 to a nursing facility unless (1) the member requires a short-term nursing facility care stay; (2) the member chooses to transition to a nursing facility and enroll in CHOICES Group 1; or (3) the CONTRACTOR determines that it cannot safely and effectively meet the needs of the member and within the member's cost neutrality cap, and the member agrees to transition to a nursing facility and enroll in CHOICES Group 1;
- 2.9.2.1.4.6.4 Admit a member enrolled in CHOICES Group 3 to a nursing facility unless: (1) the member meets nursing facility level of care and is expected to require nursing facility services for ninety (90) days or less; or (2) the member meets nursing facility level of care, is expected to require nursing facility services for more than ninety (90) days and chooses to transition to a nursing facility and enroll in CHOICES Group 1; or
- 2.9.2.1.4.6.5 Transition members in CHOICES Group 2 or 3 to another HCBS provider for continuing services unless the current HCBS provider is not a contract provider; if the current HCBS provider is not a contract provider, the CONTRACTOR shall provide continuation of HCBS from that provider for at least thirty (30) days, which shall be extended as necessary to ensure continuity of care pending the provider's contracting with the CONTRACTOR or the member's transition to a contract provider; if the member is transitioned to a contract provider, the CONTRACTOR shall facilitate a seamless transition to the new provider.
- 2.9.2.1.5 For CHOICES members who are transferring to the CONTRACTOR's MCO serving a Grand Region where CHOICES has been implemented from a Grand Region where

CHOICES has not yet been implemented, the CONTRACTOR shall be responsible for continuing to provide covered long-term care services, including both nursing facility services and, for members in CHOICES Group 2 or 3, HCBS in the member's approved HCBS E/D waiver plan of care. Unless and until the CONTRACTOR has been directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, only members in CHOICES Group 1 will be enrolled with the CONTRACTOR. Therefore, unless and until directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the requirements in this Section 2.9.2.1.5 applicable only to CHOICES Group 2 and/or 3 will not apply. When directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the CONTRACTOR shall, as directed by TENNCARE, comply with all of the requirements of Section 2.9.2.1.5.

- 2.9.2.1.5.1 For members in CHOICES Group 2, the CONTRACTOR shall be responsible for continuing to provide HCBS in accordance with the member's approved HCBS E/D waiver plan of care for a minimum of thirty (30) calendar days after enrollment; thereafter the CONTRACTOR shall not reduce the member's HCBS unless a care coordinator has conducted a comprehensive needs assessment and developed a plan of care, and the CONTRACTOR has authorized and initiated HCBS in accordance with the member's new plan of care. If a member in CHOICES Group 2 is receiving short-term nursing facility care, the CONTRACTOR shall continue to provide nursing facility services to the member in accordance with the level of nursing facility services (Level I or Level II) approved by TENNCARE (see Section 2.14.1.12). For a member in CHOICES Group 1, the CONTRACTOR shall provide nursing facility services to the member in accordance with the level of nursing facility services (Level I or Level II) approved by TENNCARE (see Section 2.14.1.12); however, the member may be transitioned to the community in accordance with Section 2.9.6.8 of this Agreement.
- 2.9.2.1.5.2 For a member in CHOICES Group 2, within thirty (30) days of notice of the member's enrollment, a care coordinator shall conduct a face-to-face visit (see Section 2.9.6.2.5), including a comprehensive needs assessment (see Section 2.9.6.5), and develop a plan of care (see Section 2.9.6.6), and the CONTRACTOR shall authorize and initiate HCBS in accordance with the new plan of care (see Section 2.9.6.2.5). If the member is receiving short-term nursing facility care on the date of enrollment with the CONTRACTOR, a care coordinator shall complete a face-to-face visit prior to the expiration date of the level of nursing facility services approved by TENNCARE, and within no more than thirty (30) days of the member's enrollment, to determine appropriate needs assessment and care planning activities (see Section 2.9.6.2.5 for members who will be discharged for the nursing facility and remain in CHOICES Group 2 and Section 2.9.6.2.4 for members who will remain in the nursing facility and be enrolled in CHOICES Group 1). If the expiration date for the level of nursing facility services approved by TENNCARE occurs prior to thirty (30) days after enrollment, and the CONTRACTOR is unable to conduct the face-to-face visit prior to the expiration date, the CONTRACTOR shall be responsible for facilitating discharge to the community or enrollment in CHOICES Group 1, whichever is appropriate.

- 2.9.2.1.5.3 If at any time before conducting the comprehensive needs assessment for a member in CHOICES Group 2 the CONTRACTOR becomes aware of an increase in the member's needs, a care coordinator shall immediately conduct a comprehensive needs assessment and update the member's plan of care, and the CONTRACTOR shall initiate the change in services within ten (10) days of becoming aware of the change in the member's needs.
- 2.9.2.1.5.4 For a member in CHOICES Group 1 who, at the time of enrollment with the CONTRACTOR, has resided in a nursing facility for less than ninety (90) days, a care coordinator shall conduct a face-to-face in-facility visit within thirty (30) days of the member's enrollment with the CONTRACTOR and conduct a needs assessment as determined necessary by the CONTRACTOR (see Section 2.9.6.5). For a member in CHOICES Group 1 who, at the time of enrollment with the CONTRACTOR, has resided in a nursing facility for ninety (90) days or more, a care coordinator shall conduct a face-to-face in-facility visit within sixty (60) days of the member's enrollment with the CONTRACTOR and conduct a needs assessment as determined necessary by the CONTRACTOR (see Section 2.9.6.5).
- 2.9.2.1.5.5 The CONTRACTOR shall facilitate a seamless transition to new services and/or providers, as applicable, in the plan of care developed by the CONTRACTOR without any disruption in services.
- 2.9.2.1.5.6 The CONTRACTOR shall not:
 - 2.9.2.1.5.6.1 Transition nursing facility residents or CHOICES Group 2 members who are residents of community-based residential alternatives to another facility unless (1) the member or his/her representative specifically requests to transition, which shall be documented in the member's file, (2) the member or his/her representative provides written consent to transition based on quality or other concerns raised by the CONTRACTOR, which shall not include the nursing facility's rate of reimbursement; or (c) the facility where the member is residing is not a contract provider; if the community-based residential facility where the CHOICES Group 2 member is currently residing is not a contract provider, the CONTRACTOR shall provide continuation of services in such facility for at least thirty (30) days, which shall be extended as necessary to ensure continuity of care pending the facility's contracting with the CONTRACTOR or the member's transition to a contract facility; if the member is transitioned to a contract facility, the CONTRACTOR shall facilitate a seamless transition to the new facility; if the nursing facility where the member is currently residing is a non-contract provider, the CONTRACTOR shall (a) authorize continuation of the services pending enrollment of the facility as a contract provider (except a facility excluded for a 2-year period when the facility has withdrawn from Medicaid participation); (b) authorize continuation of the services pending facilitation of the member's transition to a contract facility, subject to the member's agreement with such transition; or (c) may continue to reimburse services from the non-contract nursing facility in accordance with TennCare rules and regulations;
 - 2.9.2.1.5.6.2 Transition Group 1 members to HCBS unless the member chooses to receive HCBS as an alternative to nursing facility care and is enrolled in CHOICES

Group 2 (see Section 2.9.6.8 for requirements regarding nursing facility to community transition);

- 2.9.2.1.5.6.3 Admit a member in CHOICES Group 2 to a nursing facility unless (1) the member requires a short-term nursing facility care stay; (2) the member chooses to transition to a nursing facility and enroll in CHOICES Group 1; or (3) the CONTRACTOR determines that it cannot safely and effectively meet the needs of the member and within the member's cost neutrality cap and the member agrees to transition to a nursing facility and enroll in CHOICES Group 1; or
- 2.9.2.1.5.6.4 Transition members in CHOICES Group 2 to another HCBS provider for continuing services unless the current HCBS provider is not a contract provider; if the current HCBS provider is not a contract provider, the CONTRACTOR shall provide continuation of HCBS from that provider for at least thirty (30) days, which shall be extended as necessary to ensure continuity of care pending the provider's contracting with the CONTRACTOR or the member's transition to a contract provider; if the member is transitioned to a contract provider, the CONTRACTOR shall facilitate a seamless transition to the new provider.
- 2.9.2.2 In the event an enrollee entering the CONTRACTOR's MCO, either as a new TennCare enrollee or transferring from another MCO, is in her first trimester of pregnancy and is receiving medically necessary covered prenatal care services the day before enrollment, the CONTRACTOR shall be responsible for the costs of continuation of such medically necessary prenatal care services, including prenatal care, delivery, and post-natal care, without any form of prior approval and without regard to whether such services are being provided by a contract or non-contract provider.
 - 2.9.2.2.1 If the member is receiving services from a non-contract provider, the CONTRACTOR shall be responsible for the costs of continuation of medically necessary covered prenatal services, without any form of prior approval, until such time as the CONTRACTOR can reasonably transfer the member to a contract provider without impeding service delivery that might be harmful to the member's health.
 - 2.9.2.2.2 If the member is receiving services from a contract provider, the CONTRACTOR shall be responsible for the costs of continuation of medically necessary covered prenatal services from that provider, without any form of prior approval, through the postpartum period.
- 2.9.2.3 In the event an enrollee entering the CONTRACTOR's MCO, either as a new TennCare enrollee or transferring from another MCO, is in her second or third trimester of pregnancy and is receiving medically necessary covered prenatal care services the day before enrollment, the CONTRACTOR shall be responsible for providing continued access to the prenatal care provider (whether contract or non-contract provider) through the postpartum period, without any form of prior approval.
- 2.9.2.4 If a member enrolls in the CONTRACTOR's MCO from another MCO, the CONTRACTOR shall immediately contact the member's previous MCO and request the transfer of "transition of care data" as specified by TENNCARE. If the CONTRACTOR is contacted by another MCO requesting "transition of care data"

for a member who has transferred from the CONTRACTOR to the requesting MCO (as verified by the CONTRACTOR), the CONTRACTOR shall provide such data in the timeframe and format specified by TENNCARE.

- 2.9.2.5 If the CONTRACTOR becomes aware that a CHOICES member will be transferring to another MCO, the CONTRACTOR (including, but not limited to the member's care coordinator) shall work with the other MCO in facilitating a seamless transition for that member. If a member in CHOICES Group 2 or 3 is transferring to a Grand Region where CHOICES has not been implemented, the care coordinator shall provide the local Area Agency on Aging and Disability (AAAD) with the member's plan of care and other information specified by TENNCARE within the timeframe and in the format specified by TENNCARE and shall work with the AAAD to facilitate a seamless transition for that member.
- 2.9.2.6 The CONTRACTOR shall ensure that any member entering the CONTRACTOR's MCO is held harmless by the provider for the costs of medically necessary covered services except for applicable TennCare cost sharing and patient liability amounts (see Section 2.6.7 of this Agreement).
- 2.9.2.7 The CONTRACTOR shall develop and maintain policies and procedures regarding the transition of new members.

2.9.3 Transition of Members Receiving Long-Term Care Services at the Time of CHOICES Implementation

- 2.9.3.1 For each member who is enrolling in CHOICES Group 1 or 2 as of the date of CHOICES implementation in each Grand Region, as identified by TENNCARE (herein referred to as "transitioning CHOICES members"), the CONTRACTOR shall assign a care coordinator prior to the first face-to-face visit. If the face-to-face visit will not occur within ten (10) days after the implementation of CHOICES, the CONTRACTOR shall send the member written notification within ten (10) calendar days of implementation that explains how the member can reach the care coordination unit for assistance with concerns or questions pending the assignment of a specific care coordinator. Unless and until the CONTRACTOR has been directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 at CHOICES implementation, only members in CHOICES Group 1 will transition at the time of CHOICES implementation. Therefore, the requirements in this Section 2.9.3 applicable only to CHOICES Group 2 will not apply unless otherwise directed by TENNCARE.
- 2.9.3.2 For each transitioning CHOICES member, the CONTRACTOR shall be responsible for the costs of continuing to provide covered long-term care services previously authorized by TENNCARE or its designee, including, as applicable, nursing facility services or, for members in CHOICES Group 2, HCBS in the member's approved HCBS E/D waiver plan of care without regard to whether such services are being provided by contract or non-contract providers.
- 2.9.3.3 For members in CHOICES Group 2 the CONTRACTOR shall continue HCBS in the member's approved HCBS E/D waiver plan of care except case management for a minimum of thirty (30) days after the member's enrollment and thereafter shall not reduce HCBS unless the member's care coordinator has conducted a comprehensive

needs assessment and developed a plan of care and the CONTRACTOR has authorized and initiated HCBS in accordance with the member's new plan of care. If a member in CHOICES Group 2 is receiving short-term nursing facility care, the CONTRACTOR shall continue to provide nursing facility services to the member in accordance with the level of nursing facility services (Level I or Level II) approved by TENNCARE (see Section 2.14.1.12).

- 2.9.3.4 For a member in CHOICES Group 2, within ninety (90) days of CHOICES implementation, the member's care coordinator shall conduct a face-to-face visit (see Section 2.9.6.2.5), including a comprehensive needs assessment (see Section 2.9.6.5), and develop a plan of care (see Section 2.9.6.6), and the CONTRACTOR shall authorize and initiate HCBS in accordance with the new plan of care. If a member in CHOICES Group 2 is receiving short-term nursing facility care on the date of enrollment with the CONTRACTOR the member's care coordinator shall complete a face-to-face visit prior to the expiration date of the level of nursing services approved by TENNCARE, but no more than ninety (90) days after CHOICES implementation, to determine appropriate needs assessment and care planning activities (see Section 2.9.6.2.5 for members who will be discharged from the nursing facility and remain in CHOICES Group 2 or 3 and Section 2.9.6.2.4 for members who will remain in the nursing facility and be enrolled in CHOICES Group 1). If the expiration date for the level of nursing facility services approved by TENNCARE occurs prior to ninety (90) days after CHOICES implementation, and the CONTRACTOR is unable to conduct the face-to-face visit prior to the expiration date, the CONTRACTOR shall be responsible for facilitating discharge to the community or enrollment in CHOICES Group 1, whichever is appropriate.
- 2.9.3.5 If at any time before conducting a comprehensive needs assessment for a member in CHOICES Group 2 the CONTRACTOR becomes aware of an increase in the member's needs, the member's care coordinator shall immediately conduct a comprehensive needs assessment and update the member's plan of care, and the CONTRACTOR shall initiate the change in services within ten (10) days of becoming aware of the change in the member's needs.
- 2.9.3.6 The CONTRACTOR shall provide nursing facility services to a member in CHOICES Group 1 in accordance with the level of nursing facility services (Level I or Level II) approved by TENNCARE (see Section 2.14.1.12); however, the member may be transitioned to the community in accordance with Section 2.9.6.8 of this Agreement.
- 2.9.3.7 For a member in CHOICES Group 1 who, at the time of enrollment with the CONTRACTOR, has resided in a nursing facility for less than ninety (90) days, the member's care coordinator shall conduct a face-to-face in-facility visit within ninety (90) days of the implementation of CHOICES and conduct a needs assessment as determined necessary by the CONTRACTOR (see Section 2.9.6.5.1). For a member in CHOICES Group 1 who, at the time of implementation of CHOICES, has resided in a nursing facility for ninety (90) days or more, the member's care coordinator shall conduct a face-to-face in-facility visit within six (6) months of the member's enrollment with the CONTRACTOR and conduct a needs assessment as determined necessary by the CONTRACTOR (see Section 2.9.6.5.1).

- 2.9.3.8 The CONTRACTOR shall facilitate a seamless transition to new services and/or providers, as applicable, in the plan of care developed by the CONTRACTOR without any disruption in services.
- 2.9.3.9 The CONTRACTOR shall not:
 - 2.9.3.9.1 Transition nursing facility residents or CHOICES Group 2 members who are residents of community-based residential alternatives to another facility unless (1) the member or his/her representative specifically requests to transition, which shall be documented in the member's file, (2) the member or his/her representative provides written consent to transition based on quality or other concerns raised by the CONTRACTOR, which shall not include the nursing facility's rate of reimbursement; or (3) the facility where the member is residing is not a contract provider; if the community-based residential facility where the CHOICES Group 2 member is currently residing is not a contract provider, the CONTRACTOR shall provide continuation of services in such facility for at least thirty (30) days, which shall be extended as necessary to ensure continuity of care pending the facility's contracting with the CONTRACTOR or the member's transition to a contract facility; if the member is transitioned to a contract facility, the CONTRACTOR shall facilitate a seamless transition to the new facility; if the nursing facility where the member is currently residing is a non-contract provider, the CONTRACTOR shall (a) authorize continuation of the services pending enrollment of the facility as a contract provider (except a facility excluded for a 2-year period when the facility has withdrawn from Medicaid participation); (b) authorize continuation of the services pending facilitation of the member's transition to a contract facility, subject to the member's agreement with such transition; or (c) may continue to reimburse services from the non-contract nursing facility in accordance with TennCare rules and regulations;
 - 2.9.3.9.2 Transition Group 1 members to HCBS unless the member chooses to receive HCBS as an alternative to nursing facility care and is enrolled in CHOICES Group 2 (see Section 2.9.6.8 for requirements regarding nursing facility to community transition);
 - 2.9.3.9.3 Admit a member in CHOICES Group 2 to a nursing facility unless (1) the member requires a short-term nursing facility care stay; (2) the member chooses to transition to a nursing facility and enroll in CHOICES Group 1; or (3) the CONTRACTOR determines that it cannot safely and effectively meet the needs of the member and within the member's cost neutrality cap, and the member agrees to transition to a nursing facility and enroll in CHOICES Group 1; or
 - 2.9.3.9.4 Transition members in CHOICES Group 2 or 3 to another HCBS provider for continuing services unless the current HCBS provider is not a contract provider; if the current HCBS provider is not a contract provider, the CONTRACTOR shall provide continuation of HCBS from that provider for at least thirty (30) days, which shall be extended as necessary to ensure continuity of care pending the provider's contracting with the CONTRACTOR or the member's transition to a contract provider; if the member is transitioned to a contract provider, the CONTRACTOR shall facilitate a seamless transition to the new provider.

2.9.4 Transition of Care

- 2.9.4.1 The CONTRACTOR shall actively assist members with chronic or acute medical or behavioral health conditions, members who are receiving long-term care services, and members who are pregnant in transitioning to another provider when a provider currently treating their chronic or acute medical or behavioral health condition, currently providing their long-term care services, or currently providing prenatal services has terminated participation with the CONTRACTOR. For CHOICES members, this assistance shall be provided by the member's care coordinator/care coordination team.
- 2.9.4.1.1 Except as provided below regarding members who are in their second or third trimester of pregnancy, the CONTRACTOR shall provide continuation of such provider for up to ninety (90) calendar days or until the member may be reasonably transferred to another provider without disruption of care, whichever is less.
- 2.9.4.1.2 For members in their second or third trimester of pregnancy, the CONTRACTOR shall allow continued access to the member's prenatal care provider and any provider currently treating the member's chronic or acute medical or behavioral health condition or currently providing long-term care services, through the postpartum period.
- 2.9.4.2 The CONTRACTOR shall actively assist members in transitioning to another provider when there are changes in providers. The CONTRACTOR shall have transition policies that, at a minimum, include the following:
- 2.9.4.2.1 A schedule which ensures transfer does not create a lapse in service;
- 2.9.4.2.2 For members in CHOICES Groups 2 and 3, the requirement for a HCBS provider that is no longer willing or able to provide services to a member to cooperate with the member's care coordinator to facilitate a seamless transition to another HCBS provider (see Section 2.12.12.1) and to continue to provide services to the member until the member has been transitioned to another HCBS provider, as determined by the CONTRACTOR, or as otherwise directed by the CONTRACTOR (see Section 2.12.12.2);
- 2.9.4.2.3 A mechanism for timely information exchange (including transfer of the member record);
- 2.9.4.2.4 A mechanism for assuring confidentiality;
- 2.9.4.2.5 A mechanism for allowing a member to request and be granted a change of provider;
- 2.9.4.2.6 An appropriate schedule for transitioning members from one (1) provider to another when there is medical necessity for ongoing care.
- 2.9.4.2.7 Specific transition language on the following special populations:
- 2.9.4.2.7.1 Children who are SED;
- 2.9.4.2.7.2 Adults who are SPMI;

- 2.9.4.2.7.3 Persons who have addictive disorders;
- 2.9.4.2.7.4 Persons who have co-occurring disorders of both mental health and substance abuse disorders; and
- 2.9.4.2.7.5 Persons with behavioral health conditions who also have a developmental disorder (dually diagnosed). These members shall be allowed to remain with their providers of the services listed below for the minimum time frames set out below as long as the services continue to be medically necessary. The CONTRACTOR may shorten these transition time frames only when the provider of services is no longer available to serve the member or when a change in providers is agreed to in writing by the member.
 - 2.9.4.2.7.5.1 Mental health case management: three (3) months;
 - 2.9.4.2.7.5.2 Psychiatrist: three (3) months;
 - 2.9.4.2.7.5.3 Outpatient behavioral health therapy: three (3) months;
 - 2.9.4.2.7.5.4 Psychosocial rehabilitation and supported employment: three (3) months; and
 - 2.9.4.2.7.5.5 Psychiatric inpatient or residential treatment and supported housing: six (6) months.

2.9.5 MCO Case Management

- 2.9.5.1 The CONTRACTOR shall maintain an MCO case management program that includes the following components:
 - 2.9.5.1.1 A systematic approach to identify eligible members;
 - 2.9.5.1.2 Assessment of member needs;
 - 2.9.5.1.3 Development of an individualized plan of care;
 - 2.9.5.1.4 Implementation of the plan of care, including coordination of care that actively links the member to providers and support services; and
 - 2.9.5.1.5 Program Evaluation (Satisfaction and Effectiveness).
- 2.9.5.2 The CONTRACTOR shall provide MCO case management to members who are at high risk or have unique, chronic, or complex needs. This shall include but not be limited to members with co-occurring mental illness and substance abuse and/or co-morbid physical health and behavioral health conditions.
- 2.9.5.3 The CONTRACTOR has the option of allowing members to be enrolled in both MCO case management and a disease management program.
- 2.9.5.4 The CONTRACTOR shall ensure that, upon a member's enrollment in CHOICES, MCO case management activities are integrated with CHOICES care coordination

processes and functions, and that the member's assigned care coordinator has primary responsibility for coordination of all the member's physical health, behavioral health, and long-term care needs. The care coordinator may use resources and staff from the CONTRACTOR's MCO case management program, including persons with specialized expertise in areas such as behavioral health, to supplement but not supplant the role and responsibilities of the member's care coordinator/care coordination team.

- 2.9.5.5 Eligible members shall be offered MCO case management services. However, member participation shall be voluntary.
- 2.9.5.6 The CONTRACTOR shall develop a process to inform members and providers about the availability of MCO case management and to inform the member's PCP and/or appropriate specialist when a member has been assigned to the MCO case management program.
- 2.9.5.7 The CONTRACTOR shall use utilization data, including pharmacy data provided by TENNCARE or its PBM (see Section 2.9.10), to identify members for MCO case management services as appropriate. In particular, the CONTRACTOR shall track utilization data to determine when a member has exceeded the ED threshold (see Section 2.14.1.13).

2.9.6 Care Coordination

2.9.6.1 General

- 2.9.6.1.1 The CONTRACTOR shall provide care coordination to all members enrolled in TennCare CHOICES in accordance with this Agreement and to other TennCare members only in order to determine the member's eligibility for and facilitate the member's enrollment in TennCare CHOICES. Except for the initial process for current members that is necessary to determine the member's eligibility for and facilitate the member's enrollment in TennCare CHOICES, care coordination shall not be available to non-CHOICES members. Unless and until directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the requirements in this Section 2.9.6 applicable only to CHOICES Group 2 and/or 3 will not apply. If and when directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the CONTRACTOR shall, as directed by TENNCARE, comply with all of the requirements in this Section 2.9.6.
- 2.9.6.1.2 The CONTRACTOR shall provide care coordination in a comprehensive, holistic, person-centered manner.
- 2.9.6.1.3 The CONTRACTOR shall use care coordination as the continuous process of: (1) assessing a member's physical, behavioral, functional, and psychosocial needs; (2) identifying the physical health, behavioral health and long-term care services and other social support services and assistance (e.g., housing or income assistance) that are necessary to meet identified needs; (3) ensuring timely access to and provision, coordination and monitoring of physical health, behavioral health, and long-term care services needed to help the member maintain or improve his or her physical or behavioral health status or functional abilities and maximize independence; and

(4) facilitating access to other social support services and assistance needed in order to ensure the member's health, safety and welfare, and as applicable, to delay or prevent the need for more expensive institutional placement.

- 2.9.6.1.4 Long-term care services identified through care coordination and provided by the CONTRACTOR shall build upon and not supplant a member's existing support system, including but not limited to informal supports provided by family and other caregivers, services that may be available at no cost to the member through other entities, and services that are reimbursable through other public or private funding sources, such as Medicare or long-term care insurance.
- 2.9.6.1.5 The CONTRACTOR shall develop and implement policies and procedures for care coordination that comply with the requirements of this Agreement.
- 2.9.6.1.6 The CONTRACTOR's failure to meet requirements, including timelines, for care coordination set forth in this Agreement, except for good cause, constitutes non-compliance with this Agreement. Such failure shall not affect any determination of eligibility for CHOICES enrollment, which shall be based only on whether the member meets CHOICES eligibility and enrollment criteria, as defined pursuant to the Section 1115 TennCare Demonstration Waiver, federal and state laws and regulations, this Agreement, and TennCare policies and protocols. Nor shall such failure affect any determination of coverage for CHOICES benefits which shall be based only on the covered benefits for the applicable CHOICES group in which the member is enrolled as defined pursuant to the Section 1115 TennCare Demonstration Waiver, federal and state laws and regulations, this Agreement, and TennCare policies and protocols; and in accordance with requirements pertaining to medical necessity.
- 2.9.6.1.7 The CONTRACTOR shall ensure that its care coordination program complies with 42 CFR 438.208.
- 2.9.6.1.8 The CONTRACTOR shall ensure that, upon enrollment into CHOICES, MCO case management and/or disease management activities are integrated with CHOICES care coordination processes and functions, and that the member's assigned care coordinator has primary responsibility for coordination of all the member's physical health, behavioral health, and long-term care needs, including appropriate management of conditions specified in 2.8.1.1. The care coordinator may use resources and staff from the CONTRACTOR's case management and disease management programs, including persons with specialized expertise in areas such as behavioral health, to supplement but not supplant the role and responsibilities of the care coordinator/care coordination team.
- 2.9.6.2 Intake Process for Members New to Both TennCare and CHOICES
 - 2.9.6.2.1 The CONTRACTOR shall refer all inquiries regarding CHOICES enrollment by or on behalf of individuals who are not enrolled with the CONTRACTOR to TENNCARE or its designee. The form and format for such referrals shall be developed in collaboration with the CONTRACTOR and TENNCARE or its designee.

- 2.9.6.2.2 TENNCARE or its designee will assist individuals who are not enrolled in TennCare with TennCare eligibility and CHOICES enrollment.
- 2.9.6.2.3 *Functions of the Single Point of Entry (SPOE)*
- 2.9.6.2.3.1 For persons wishing to apply for CHOICES, TENNCARE or its designee may employ a screening process, using the tool and protocols specified by TENNCARE, to assist with intake for persons new to both TennCare and CHOICES. Such screening process shall assess: (1) whether the applicant appears to meet categorical and financial eligibility criteria for CHOICES; (2) whether the applicant appears to meet nursing facility level of care; and (3) for applicants seeking access to HCBS through enrollment in CHOICES Group 2, whether it appears that the applicant's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care.
- 2.9.6.2.3.2 For persons identified by TENNCARE or its designee as meeting the screening criteria, or for whom TENNCARE or its designee opts not to use a screening process, TENNCARE or its designee will conduct a face-to-face intake visit with the applicant. As part of this intake visit TENNCARE or its designee will, using the tools and protocols specified by TENNCARE, conduct a level of care and needs assessment; assess the member's existing natural support system, including but not limited to informal supports provided by family and other caregivers, services that may be available at no cost to the member through other entities, and services that are reimbursable through other public or private funding sources, such as Medicare or long-term care insurance; and identify the long-term care services and home health and/or private duty nursing services that may be needed by the applicant upon enrollment into CHOICES that would build upon and not supplant a member's existing natural support system.
- 2.9.6.2.3.3 TENNCARE or its designee shall conduct the intake visit, including the level of care and needs assessment, in the applicant's place of residence, except under extenuating circumstances (such as the member's hospitalization), which shall be documented in writing.
- 2.9.6.2.3.4 As part of the intake visit, TENNCARE or its designee shall: (1) provide general CHOICES education and information, as specified by TENNCARE, and assist in answering any questions the applicant may have; (2) provide information about estate recovery; (3) provide choice counseling and facilitate the selection of an MCO by the applicant or his/her representative; (4) provide information regarding freedom of choice of nursing facility versus HCBS, both verbally and in writing, and obtain a Freedom of Choice form signed by the applicant or his/her representative; (5) for applicants who want to receive NF services (a) provide detailed information and signed acknowledgement of understanding regarding a CHOICES member's responsibility with respect to payment of patient liability amounts, including, as applicable, the potential consequences for non-payment of patient liability which may include loss of the member's current nursing facility provider, disenrollment from CHOICES, and to the extent the member's eligibility is dependent on receipt of long-term care services, possible loss of eligibility for TennCare; and (b) provide information regarding the completion of all PASRR requirements prior to nursing facility admission and conduct the level I PASRR screening; (6) for applicants who are seeking HCBS:

(a) conduct a risk assessment using a tool and protocol specified by TENNCARE and develop, as applicable, a risk agreement that shall be signed by the applicant or his/her representative and which shall include identified risks to the applicant, the consequences of such risks, strategies to mitigate the identified risks, and the applicant's decision regarding his/her acceptance of risk; (b) make a determination regarding whether the applicant's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care, including explanation to the applicant regarding the individual cost neutrality cap, and notification to and signed acknowledgement of understanding by the applicant or his/her representative that a change in a member's needs or circumstances that would result in the cost neutrality cap being exceeded or that would result in the MCO's inability to safely and effectively meet a member's needs in the community and within the cost neutrality cap may result in the member's disenrollment from CHOICES Group 2, in which case, the care coordinator will assist with transition to a more appropriate care delivery setting; and (c) provide information regarding consumer direction and obtain signed documentation of the applicant's interest in participating in consumer direction; and (7) provide information regarding next steps in the process including the need for approval by TENNCARE to enroll in CHOICES and the functions of the CONTRACTOR, including that the CONTRACTOR will develop and approve a plan of care.

- 2.9.6.2.3.5 The listing of HCBS and home health and/or private duty nursing services the member may need shall be used by TENNCARE or its designee to determine whether services can be provided within the member's cost neutrality cap and may be further refined based on the CONTRACTOR's comprehensive needs assessment and plan of care development processes.
- 2.9.6.2.3.6 The State will be responsible for determining TennCare categorical and financial eligibility and level of care and enrolling eligible TennCare members into CHOICES.
- 2.9.6.2.3.7 TENNCARE will notify the CONTRACTOR via the 834 eligibility file when a person has been enrolled in CHOICES and the member's CHOICES Group and applicable patient liability amounts (see Section 2.6.7.2). For members in CHOICES Group 2, TENNCARE will notify the CONTRACTOR of the member's cost neutrality cap (see definition in Section 1 and see Section 2.6.1.5.2.3).
- 2.9.6.2.3.8 TENNCARE or its designee will make available to the CONTRACTOR the documentation from the intake visit, including but not limited to the member's level of care and needs assessment, the assessment of the member's existing natural support system, the member's risk assessment and signed risk agreement (for members in CHOICES Group 2), and the services identified by TENNCARE or its designee.
- 2.9.6.2.4 *Functions of the CONTRACTOR for Members in CHOICES Group 1*
 - 2.9.6.2.4.1 For members enrolled in CHOICES Group 1, who are, upon CHOICES enrollment, receiving nursing facility services, the CONTRACTOR shall immediately authorize such services in accordance with the level of nursing

facility services (Level I or Level II) approved by TENNCARE (see Section 2.14.1.12). Authorization for such services shall be from the current provider as of the effective date of CHOICES enrollment. The CONTRACTOR shall not move members enrolled in CHOICES Group 1 who are, upon CHOICES enrollment, receiving nursing facility services, to another facility unless: (1) the member or his/her representative specifically requests to move, which shall be documented in the member's file; (2) the member or his/her representative provides written consent to move based on quality or other concerns raised by the CONTRACTOR, which shall not include the nursing facility's rate of reimbursement; or (3) the facility where the member is residing is not a contract provider. If the nursing facility is a non-contract provider, the CONTRACTOR shall (a) authorize continuation of the services pending enrollment of the facility as a contract provider (except a facility excluded for a 2-year period when the facility has withdrawn from Medicaid participation); (b) authorize continuation of the services pending facilitation of the member's transition to a contract facility, subject to the member's agreement with such transition; or (c) may continue to reimburse services from the non-contract nursing facility in accordance with TennCare rules and regulations.

- 2.9.6.2.4.2 For members in CHOICES Group 1 who are receiving services in a nursing facility at the time of enrollment in CHOICES and have received such services for ninety (90) days or more, the CONTRACTOR shall, within sixty (60) calendar days of notice of the member's enrollment in CHOICES, conduct a face-to-face visit with the member and perform any additional needs assessment deemed necessary by the CONTRACTOR (see Section 2.9.6.5.1). The care coordinator shall review the plan of care developed by the nursing facility and may supplement the plan of care as necessary and appropriate (see Section 2.9.6.6.1).
- 2.9.6.2.4.3 The care coordinator shall, for members in CHOICES Group 1 who are receiving services in a nursing facility at the time of enrollment in CHOICES and are new admissions to a nursing facility, having resided in the nursing facility for less than ninety (90) days, within thirty (30) calendar days of notice of the member's enrollment in CHOICES conduct a face-to-face visit with the member and perform any additional needs assessment deemed necessary by the CONTRACTOR (see Section 2.9.6.5.1). The care coordinator shall review the plan of care developed by the nursing facility and may supplement the plan of care as necessary and appropriate (see in Section 2.9.6.6.1).
- 2.9.6.2.4.4 For members in CHOICES Group 1 who are waiting for placement in a nursing facility, within ten (10) calendar days of notice of the member's enrollment in CHOICES (1) the member's care coordinator shall conduct a face-to-face visit with the member, which shall include (a) member education regarding choice of contract nursing facility providers, subject to the provider's availability and willingness to timely delivery services, and obtain signed confirmation of the member's choice of nursing facility; and (b) performing any additional needs assessment deemed necessary by the CONTRACTOR (see Section 2.9.6.5.1); and (2) the CONTRACTOR shall authorize and initiate nursing facility services. Upon admission to a nursing facility, the care coordinator shall participate as appropriate in the nursing facility's care planning process (see Section

- 2.9.6.6.1.2) and may supplement the plan of care as necessary (see Section 2.9.6.6.1.1).
- 2.9.6.2.4.5 The CONTRACTOR shall not divert or transition members in CHOICES Group 1 to HCBS unless the member chooses to receive HCBS as an alternative to nursing facility and is enrolled in CHOICES Group 2 or 3.
- 2.9.6.2.4.6 The CONTRACTOR shall ensure that all PASRR requirements are met prior to a member's admission to a nursing facility.
- 2.9.6.2.4.7 For purposes of the CHOICES program, service authorization for nursing facility services shall be for the level of nursing facility services (Level I or Level II) approved by TENNCARE (see Section 2.14.1.12) and shall include the duration of nursing facilities services to be provided; the requested start date; and other relevant information as prescribed by TENNCARE. The CONTRACTOR shall be responsible for confirming the nursing facility's capacity and commitment to initiate services as authorized on or before the requested start date, and if the nursing facility is unable to initiate services as authorized on or before the requested start date, for arranging an alternative nursing facility that is able to initiate services as authorized on or before the requested start date in accordance with Section 2.9.6.2.4.8.
- 2.9.6.2.4.8 If the CONTRACTOR is unable to place a member in the nursing facility requested by the member, the care coordinator shall meet with the member and his/her representative to discuss the reasons why the member cannot be placed with the requested nursing facility and the available options and identify an alternative nursing facility.
- 2.9.6.2.4.9 If the CONTRACTOR is unable to initiate nursing facility services in accordance with the timeframes specified in Section 2.9.6.2.4.4, the CONTRACTOR shall issue written notice to the member, documenting that the service will be delayed, the reasons for the delay, and the date the service will start, and shall make good faith efforts to ensure that services are provided as soon as practical.
- 2.9.6.2.4.10 For CHOICES members approved by TENNCARE for Level II (or skilled) nursing facility services, the CONTRACTOR shall be responsible for monitoring the member's continued need for Medicaid reimbursed skilled and/or rehabilitation services, promptly notifying TENNCARE when Level II nursing facility services are no longer medically necessary, and for the submission of information needed by TENNCARE to reevaluate the member's level of care for nursing facility services (see also Section 2.14.1.12.2).
- 2.9.6.2.5 *Functions of the CONTRACTOR for Members in CHOICES Groups 2 and 3*
- 2.9.6.2.5.1 For members enrolled in CHOICES Group 2 who are, upon CHOICES enrollment, receiving community-based residential alternative services, the CONTRACTOR shall, immediately upon notice of the member's enrollment in CHOICES, authorize such services from the current provider as of the effective date of CHOICES enrollment. In the case of those members enrolled in CHOICES Group 2 on the basis of Immediate Eligibility for CHOICES Group 2, community-based residential alternative services shall be authorized immediately

upon notice of the member's categorical and financial eligibility for TennCare CHOICES as of the effective date of CHOICES enrollment. The CONTRACTOR shall not transition members enrolled in CHOICES Group 2 who are, upon CHOICES enrollment, receiving services in a community-based residential alternative setting to another facility unless: (1) the member or his/her representative specifically requests to move, which shall be documented in the member's file; (2) the member or his/her representative provides written consent to move based on quality or other concerns raised by the CONTRACTOR; or (3) the facility where the member is residing is not a contract provider; if the facility is a non-contract provider, the CONTRACTOR shall authorize medically necessary services from the non-contract provider for at least thirty (30) days which shall be extended as necessary to ensure continuity of care pending the facility's enrollment with the CONTRACTOR or the member's transition to a contract provider

- 2.9.6.2.5.2 For members in CHOICES Group 2 who upon CHOICES enrollment are receiving services in a community-based residential alternative setting, within ten (10) calendar days of notice of the member's enrollment in CHOICES the care coordinator shall conduct a face-to-face visit with the member, perform a comprehensive needs assessment (see Section 2.9.6.5), develop a plan of care (see Section 2.9.6.6), and authorize and initiate additional HCBS specified in the plan of care (i.e., assistive technology), except in the case of members enrolled on the basis of Immediate Eligibility for CHOICES Group 2. If a member residing in a community-based residential alternative setting is enrolled on the basis of Immediate Eligibility for CHOICES Group 2, the CONTRACTOR shall, upon notice that the State has determined that the member meets categorical and financial eligibility for TennCare CHOICES, immediately authorize community-based residential services and shall authorize and initiate additional HCBS specified in the member's plan of care (i.e., assistive technology) within five (5) days of notice; authorization for community-based residential alternative services shall be retroactive to the member's effective date of CHOICES enrollment.
- 2.9.6.2.5.3 The care coordinator shall, for all other members in CHOICES Groups 2 and 3 not specified in 2.9.6.2.5.1 – 2.9.6.2.5.2 above, within ten (10) calendar days of notice of the member's enrollment in CHOICES, conduct a face-to-face visit with the member, perform a comprehensive needs assessment (see Section 2.9.6.5), develop a plan of care (see Section 2.9.6.6), and authorize and initiate HCBS, except in the case of members enrolled on the basis of Immediate Eligibility for CHOICES Group 2 in which case only the limited package of HCBS shall be authorized and initiated. Members enrolled on the basis of Immediate Eligibility for CHOICES Group 2 shall have access only to a limited package of HCBS (see Section 2.6.1.5.3) pending determination of categorical and financial eligibility for TennCare CHOICES; however all needed services shall be listed in the plan of care, and the CONTRACTOR shall immediately revise the service authorizations as necessary upon notice that the State has determined that the member meets categorical and financial eligibility for TennCare CHOICES and initiate services within five (5) days of notice.
- 2.9.6.2.5.4 At the discretion of the CONTRACTOR, authorization of home health or private duty nursing services may be completed by the care coordinator or through the CONTRACTOR's established UM processes but shall be in accordance with

Section 2.9.2.1 of this Agreement, which requires the CONTRACTOR to continue providing medically necessary home health or private duty nursing services the member was receiving upon TennCare enrollment.

- 2.9.6.2.5.5 The CONTRACTOR shall not admit a member enrolled in CHOICES Group 2 to a nursing facility unless: (1) the member requires a short-term nursing facility care stay; (2) the member chooses to transition to a nursing facility and enroll in CHOICES Group 1; or (3) the CONTRACTOR determines that it cannot safely and effectively meet the needs of the member and at a cost that is less than the member's cost neutrality cap and the member agrees to transition to a nursing facility and enroll in CHOICES Group 1.
- 2.9.6.2.5.6 The CONTRACTOR shall not admit a member enrolled in CHOICES Group 3 to a nursing facility unless: (1) the member meets nursing facility level of care and is expected to require nursing facility services for ninety (90) days or less; or (2) the member meets nursing facility level of care, is expected to require nursing facility services for more than ninety (90) days and chooses to transition to a nursing facility and enroll in CHOICES Group 1.
- 2.9.6.2.5.7 In preparation for the face-to-face visit, the care coordinator shall review in-depth the information from the SPOE's intake process (see Section 2.9.6.2.3), and the care coordinator shall consider that information, including the services identified by TENNCARE or its designee, when developing the member's plan of care.
- 2.9.6.2.5.8 As part of the face-to-face visit for members in CHOICES Group 2, the care coordinator shall review, and revise as necessary, the member's risk assessment and risk agreement and have the member or his/her representative sign any revised risk agreement.
- 2.9.6.2.5.9 As part of the face-to-face visit, for members determined to need eligible HCBS, the care coordinator shall verify the member's interest in participating in consumer direction and obtain written confirmation of the member's decision. The care coordinator shall also provide member education regarding choice of contract providers for HCBS, subject to the provider's availability and willingness to timely deliver services, and obtain signed confirmation of the member's choice of contract providers.
- 2.9.6.2.5.10 For purposes of the CHOICES program, service authorizations shall include the amount, frequency, and duration of each service to be provided and the schedule at which such care is needed, as applicable; the requested start date; and other relevant information as prescribed by TENNCARE. The CONTRACTOR shall be responsible for confirming the provider's capacity and commitment to initiate services as authorized on or before the requested start date, and if the provider is unable to initiate services as authorized on or before the requested start date, for arranging an alternative provider who is able to initiate services as authorized on or before the requested start date.
- 2.9.6.2.5.11 The member's care coordinator/care coordination team shall provide at least verbal notification to the member prior to initiation of HCBS identified in the plan of care regarding any change in providers selected by the member for each HCBS, including the reason such change has been made.

- 2.9.6.2.5.12 If the CONTRACTOR is unable to initiate any HCBS in accordance with the timeframes specified herein, the CONTRACTOR shall issue written notice to the member, documenting the service(s) that will be delayed, the reasons for the delay, and the date the service(s) will start, and shall make good faith efforts to ensure that services are provided as soon as practical.
- 2.9.6.2.5.13 TENNCARE may establish, pursuant to policies and protocols for management of waiting lists, alternative timeframes for completion of specified intake functions and activities when there is a waiting list, which may include at the time of CHOICES implementation.
- 2.9.6.3 CHOICES Intake Process for the CONTRACTOR's Current Members
 - 2.9.6.3.1 The CONTRACTOR shall develop and implement policies and procedures for ongoing identification of members who may be eligible for CHOICES. The CONTRACTOR shall use the following, at a minimum, to identify members who may be eligible for CHOICES:
 - 2.9.6.3.1.1 Referral from member's PCP, specialist or other provider or other referral source;
 - 2.9.6.3.1.2 Self-referral by member or referral by member's family or guardian;
 - 2.9.6.3.1.3 Referral from CONTRACTOR's staff including but not limited to DM, MCO case management, and UM staff;
 - 2.9.6.3.1.4 Notification of hospital admission (see Section 2.12.9.38); and
 - 2.9.6.3.1.5 Upon notice from TENNCARE, periodic review (at least quarterly) of:
 - 2.9.6.3.1.5.1 Claims or encounter data;
 - 2.9.6.3.1.5.2 Hospital admission or discharge data;
 - 2.9.6.3.1.5.3 Pharmacy data; and
 - 2.9.6.3.1.5.4 Data collected through the DM and/or UM processes.
 - 2.9.6.3.1.5.5 The CONTRACTOR may define in its policies and procedures other steps that will be taken to better assess if the members identified through means other than referral or notice of hospital admission will likely qualify for CHOICES, and may target its screening and intake efforts to a more targeted list of persons that are most likely to need and to qualify for CHOICES services.
 - 2.9.6.3.2 As part of its identification process for members who may be eligible for CHOICES, the CONTRACTOR may initiate a telephone screening process, using the tool and protocols specified by TENNCARE. Such screening process shall: (1) verify the member's current eligibility category based on information provided by TENNCARE in the 834 eligibility file; for persons seeking access to HCBS through enrollment in CHOICES Groups 2 or 3, identify whether the member meets categorical eligibility requirements for enrollment in such group based on his/her current eligibility

category, and if not, for persons seeking to enroll in CHOICES Group 2, whether the member appears to meet categorical and financial eligibility criteria for the Institutional (i.e., CHOICES 217-Like HCBS) category); (2) determine whether the member appears to meet level of care eligibility for CHOICES; and (3) for members seeking access to HCBS through enrollment in CHOICES Group 2, determine whether it appears that the member's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care. Such telephone screening shall be conducted at the time of the initial call by the CONTRACTOR unless the member requests that the screening be conducted at another time, which shall be documented in writing in the CHOICES intake record.

- 2.9.6.3.3 For CHOICES referrals by or on behalf of a potential CHOICES member, regardless of referral source, if the CONTRACTOR opts to use a telephone screening process, the CONTRACTOR shall make every effort to conduct such screening process at the time of referral, unless the person making the referral is not able or not authorized by the member to assist with the screening process, in which case the CONTRACTOR shall complete the telephone screening process as expeditiously as possible.
 - 2.9.6.3.3.1 Documentation of at least three (3) attempts to contact the member by phone (which shall include at least one (1) attempt to contact the member at the number most recently reported by the member and at least one (1) attempt to contact the member at the number provided in the referral, if different), followed by a letter sent to the member's most recently reported address that provides information about CHOICES and how to obtain a screening for CHOICES, shall constitute sufficient effort by the CONTRACTOR to assist a member who has been referred for CHOICES, regardless of referral source.
- 2.9.6.3.4 For persons identified through notification of hospital admission, the CONTRACTOR shall work with the discharge planner to determine whether long-term care services may be needed upon discharge, and if so, shall complete all applicable screening and/or intake processes immediately to facilitate timely transition to the most integrated and cost effective long-term care delivery setting appropriate for the member's needs.
- 2.9.6.3.5 For identification by the CONTRACTOR of a member who may be eligible for CHOICES by means other than referral or notice of hospital admission, if the CONTRACTOR opts to use a telephone screening process, the CONTRACTOR shall complete the telephone screening process as expeditiously as possible.
 - 2.9.6.3.5.1 Documentation of at least one (1) attempt to contact the member by phone at the number most recently reported by the member, followed by a letter sent to the member's most recently reported address that provides information about CHOICES and how to obtain a screening for CHOICES shall constitute sufficient effort by the CONTRACTOR to assist a member that has been identified by the CONTRACTOR by means other than referral.
- 2.9.6.3.6 If the CONTRACTOR uses a telephone screening process, the CONTRACTOR shall document all screenings conducted by telephone and their disposition, with a written record.

- 2.9.6.3.7 If the member does not meet the telephone screening criteria, the CONTRACTOR shall notify the member verbally and in writing: (1) that he/she does not appear to meet the criteria for enrollment in CHOICES; (2) that he/she has the right to continue with the CHOICES intake process and, if determined not eligible, to receive notice of such denial, including the member's due process right to appeal; and (3) how, if the member wishes to proceed with the CHOICES intake process, the member can submit a written request to proceed with the CHOICES intake process to the CONTRACTOR. In the event that a member does submit such written request, the CONTRACTOR shall conduct a face-to-face intake visit, including level of care assessment and needs assessment, within five (5) business days of receipt of the member's written request.
- 2.9.6.3.8 If, through the screening process described above, or upon other identification by the CONTRACTOR of a member who appears to be eligible for CHOICES for whom the CONTRACTOR opts not to use such screening process, the care coordinator shall conduct a face-to-face intake visit with the member that includes a level of care assessment and a needs assessment (see Section 2.9.6.5) using tool(s) prior approved by TENNCARE and in accordance with the protocols specified by TENNCARE.
- 2.9.6.3.8.1 For members in a nursing facility or seeking nursing facility services, the care coordinator shall perform any additional needs assessment deemed necessary by the CONTRACTOR (see Section 2.9.6.5.1).
- 2.9.6.3.8.2 For members seeking HCBS (through enrollment in CHOICES Group 2 or 3), the care coordinator shall, using the tools and protocols specified by TENNCARE, assess the member's existing natural support system, including but not limited to informal supports provided by family and other caregivers, services that may be available at no cost to the member through other entities, and services that are reimbursable through other public or private funding sources, such as Medicare or long-term care insurance; and identify the long-term care services and home health and/or private duty nursing services that may be needed by the member upon enrollment into CHOICES that would build upon and not supplant a member's existing natural support system.
- 2.9.6.3.9 As part of the face-to-face intake visit, the care coordinator/care coordination team shall: (1) provide general CHOICES education and information, as specified by TENNCARE, to the member and assist in answering questions the member may have; (2) provide information about estate recovery; (3) provide assistance, as necessary, in facilitating gathering of categorical/financial documentation needed by DHS; (4) if the CONTRACTOR has been directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2, provide information regarding freedom of choice of nursing facility versus HCBS, both verbally and in writing, and obtain a Freedom of Choice form signed by the member or his/her representative; (5) for members who want to receive nursing facility services, (a) provide detailed information and signed acknowledgement of understanding regarding a CHOICES member's responsibility with respect to payment of patient liability amounts, including the potential consequences for non-payment of patient liability which may include loss of the member's current nursing facility provider, disenrollment from CHOICES, and to the extent the member's eligibility is dependent on receipt of long-term care services, possible loss of eligibility for TennCare; and (b) provide information regarding the completion of all

PASRR requirements prior to nursing facility admission and conduct the level I PASRR screening; (6) for members who are seeking HCBS (through enrollment in CHOICES Group 2 or 3), the care coordinator, shall: (a) conduct a risk assessment using a tool and protocol specified by TENNCARE and shall develop, as applicable, a risk agreement that shall be signed by the member or his/her representative and which shall include identified risks to the member, the consequences of such risks, strategies to mitigate the identified risks, and the member's decision regarding his/her acceptance of risk; (b) make a determination regarding whether the person's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care, including explanation to the member regarding the individual cost neutrality cap, and notification to and signed acknowledgement of understanding by the member or his/her representative that a change in needs or circumstances that would result in the cost neutrality cap being exceeded or that would result in the CONTRACTOR's inability to safely and effectively meet the member's needs in the community and within the cost neutrality cap may result in the member's disenrollment from CHOICES Group 2, in which case, the member's care coordinator will assist with transition to a more appropriate care delivery setting; and (c) provide information regarding consumer direction and obtain written confirmation of the member's decision regarding participation in consumer direction; and (7) for all members, provide information regarding choice of contract providers, subject to the provider's availability and willingness to timely deliver services, and obtain signed documentation of the member's choice of contract providers.

- 2.9.6.3.10 For CHOICES referrals by or on behalf of a potential CHOICES member, regardless of referral source, the care coordinator shall conduct the face-to-face intake visit and shall develop a plan of care, as appropriate (see Section 2.9.6.6), within six (6) business days of receipt of such referral, unless a later date is requested by the member, which shall be documented in writing in the CHOICES intake record.
- 2.9.6.3.11 For members identified by the CONTRACTOR as potentially eligible for CHOICES by means other than referral, the care coordinator shall conduct the face-to-face intake visit and shall develop a plan of care, as appropriate (see Section 2.9.6.6), within thirty (30) days of identification of the member as potentially eligible for CHOICES. For persons identified through notification of hospital admission, the CONTRACTOR shall coordinate with the hospital discharge planner to determine whether long-term care services may be needed upon discharge, and if so, complete all applicable screening and/or intake processes immediately to facilitate timely transition to the most integrated and cost effective long-term care delivery setting appropriate for the member's needs.
- 2.9.6.3.12 Once completed, the CONTRACTOR shall submit the level of care and, for members requesting HCBS, documentation, as specified by TENNCARE, to verify that the member's needs can be safely and effectively met in the community and within the cost neutrality cap to TENNCARE within one (1) business day.
- 2.9.6.3.13 If the member is seeking access to HCBS through enrollment in CHOICES Group 2 and the enrollment target for CHOICES Group 2 has been reached, the CONTRACTOR shall notify TENNCARE, at the time of submission of the level of care and needs assessment and plan of care, as appropriate, whether the person shall be placed on a waiting list for CHOICES Group 2. If the CONTRACTOR wishes to enroll the person in CHOICES Group 2 as a cost effective alternative (CEA) to

nursing facility care that would otherwise be provided, the CONTRACTOR shall submit to TENNCARE the following:

- 2.9.6.3.13.1 A written summary of the CONTRACTOR's CEA determination, including an explanation of the member's circumstances which warrant the immediate provision of nursing facility services unless HCBS are immediately available.
- 2.9.6.3.13.2 TENNCARE may request additional information as needed to confirm the CONTRACTOR's CEA determination and/or provider capacity to meet the member's needs, and shall, only upon receipt of satisfactory documentation, enroll the member in CHOICES.
- 2.9.6.3.14 The CONTRACTOR shall be responsible for (1) advising members who appear to meet the nursing facility level of care that are seeking access to HCBS through enrollment in CHOICES Group 2 when an enrollment target has been (or will soon be) reached; (2) advising such persons that they may choose to receive nursing facility services if HCBS are not immediately available; (3) determining whether the person wants nursing facility services if HCBS are not immediately available; and (4) at the CONTRACTOR's sole discretion, making a determination regarding whether enrollment in CHOICES Group 2 constitutes a CEA because the immediate provision of nursing facility services will otherwise be required and submitting appropriate documentation to TENNCARE if there is a waiting list for CHOICES Group 2 but the CONTRACTOR chooses to enroll a member in CHOICES Group 2 as a CEA (see Section 2.9.6.3.13.1).
- 2.9.6.3.15 The State will be responsible for determining TennCare categorical and financial eligibility and level of care and enrolling eligible TennCare members into CHOICES.
- 2.9.6.3.16 TENNCARE will notify the CONTRACTOR via the 834 eligibility file when a person has been enrolled in CHOICES and, if the member is enrolled in CHOICES, the member's CHOICES Group. For members in CHOICES Group 2, TENNCARE will notify the CONTRACTOR of the member's cost neutrality cap (see definition in Section 1 and see Section 2.6.1.5.2.3). For members in CHOICES Group 1, TENNCARE will notify the CONTRACTOR of applicable patient liability amounts (see Section 2.6.7.2).
- 2.9.6.3.17 The CONTRACTOR shall, within five (5) calendar days of notice of the member's enrollment in CHOICES, authorize and initiate long-term care services.
 - 2.9.6.3.17.1 For purposes of the CHOICES program, service authorizations for HCBS (for members in CHOICES Group 2 or 3) shall include the amount, frequency, and duration of each service to be provided, and the schedule at which such care is needed, as applicable; and other relevant information as prescribed by TENNCARE. Service authorizations for nursing facility services shall be for the level of nursing facility services (Level I or Level II) approved by TENNCARE (see Section 2.14.1.12) and shall include the duration of nursing facility services to be provided; the requested start date; and other relevant information as prescribed by TENNCARE. The CONTRACTOR is responsible for confirming the provider's capacity and commitment to initiate services as authorized on or before the requested start date, and if the provider is unable to initiate services as authorized on or before the requested start date, shall select an alternative

provider who is able to initiate services as authorized on or before the requested start date.

- 2.9.6.3.17.2 The CONTRACTOR shall provide at least verbal notice to a member in CHOICES Group 2 or 3 prior to initiation of HCBS identified in the plan of care regarding any change in providers selected by the member for each HCBS; including the reason such change has been made. If the CONTRACTOR is unable to place a member in the nursing facility or community-based residential alternative setting requested by the member, the care coordinator shall meet with the member and his/her representative to discuss the reasons why the member cannot be placed with the requested facility and the available options and identify an alternative facility.
- 2.9.6.3.17.3 If the CONTRACTOR is unable to initiate any long-term care service within the timeframes specified in this Agreement, the CONTRACTOR shall issue written notice to the member, documenting the service(s) that will be delayed, the reasons for the delay and the date the service(s) will start, and shall make good faith efforts to ensure that services are provided as soon as practical.
- 2.9.6.3.17.4 For members enrolled in CHOICES Groups 1 or 2 who are, upon CHOICES enrollment, receiving nursing facility or community-based residential alternative services from a contract provider, the CONTRACTOR shall authorize such services from the current provider as of the effective date of CHOICES enrollment. The CONTRACTOR shall not move members enrolled in CHOICES Groups 1 or 2 who are, upon CHOICES enrollment, receiving services in a nursing facility or community-based residential alternative setting to another facility unless: (1) the member or his/her representative specifically requests to move, which shall be documented in the member's file; (2) the member or his/her representative provides written consent to move based on quality or other concerns raised by the CONTRACTOR, which shall not include the nursing facility's rate of reimbursement; or (3) the facility where the member is residing is not a contract provider; if the community-based residential facility where the member in CHOICES Group 2 is currently residing is not a contract provider, the CONTRACTOR shall provide continuation of services in such facility for at least thirty (30) days, which shall be extended as necessary to ensure continuity of care pending the facility's contracting with the CONTRACTOR or the member's transition to a contract facility; if the member is transitioned to a contract facility, the CONTRACTOR shall facilitate a seamless transition to the new facility; if the nursing facility where the member is currently residing is a non-contract provider, the CONTRACTOR shall (a) authorize continuation of the services pending enrollment of the facility as a contract provider (except a facility excluded for a 2-year period when the facility has withdrawn from Medicaid participation); (b) authorize continuation of the services pending facilitation of the member's transition to a contract facility, subject to the member's agreement with such transition; or (c) may continue to reimburse services from the non-contract nursing facility in accordance with TennCare rules and regulations.
- 2.9.6.3.17.5 For members receiving nursing facility services, the care coordinator shall participate as appropriate in the nursing facility's care planning process (see

Section 2.9.6.5.1) and may supplement the plan of care as necessary (see Section 2.9.6.6.1).

- 2.9.6.3.17.6 The CONTRACTOR shall not divert or transition members in CHOICES Group 1 to HCBS unless the member chooses to receive HCBS as an alternative to nursing facility and is enrolled in CHOICES Group 2 or 3.
- 2.9.6.3.17.7 The CONTRACTOR shall ensure that all PASRR requirements are met prior to a member's admission to a nursing facility.
- 2.9.6.3.17.8 The CONTRACTOR shall not admit a member enrolled in CHOICES Group 2 to a nursing facility unless: (1) the member requires a short-term nursing facility care stay; (2) the member chooses to transition to a nursing facility and enroll in CHOICES Group 1; or (3) the CONTRACTOR determines that it cannot safely and effectively meet the needs of the member and at a cost that is less than the member's cost neutrality cap and the member agrees to transition to a nursing facility and enroll in CHOICES Group 1.
- 2.9.6.3.17.9 The CONTRACTOR shall not admit a member enrolled in CHOICES Group 3 to a nursing facility unless: (1) the member meets nursing facility level of care and is expected to require nursing facility services for ninety (90) days or less; or (2) the member meets nursing facility level of care, is expected to require nursing facility services for more than ninety (90) days and chooses to transition to a nursing facility and enroll in CHOICES Group 1.
- 2.9.6.3.18 TENNCARE may establish, pursuant to policies and protocols for management of waiting lists, alternative timeframes for completion of specified intake functions and activities for persons when there is a waiting list, which may include at the time of CHOICES implementation.
- 2.9.6.4 Care Coordination upon Enrollment in CHOICES
 - 2.9.6.4.1 Upon notice of a member's enrollment in CHOICES, the CONTRACTOR shall assume responsibility for all care coordination functions and activities described herein (assessment and care planning activities for members currently enrolled with the CONTRACTOR shall begin prior to CHOICES enrollment; see Section 2.9.6.3).
 - 2.9.6.4.2 The CONTRACTOR shall be responsible for all aspects of care coordination and all requirements pertaining thereto, including but not limited to requirements set forth in the Section 1115 TennCare Demonstration Waiver, federal and state laws and regulations, this Agreement, and TennCare policies and protocols.
 - 2.9.6.4.3 The CONTRACTOR shall assign to each member a specific care coordinator who shall have primary responsibility for performance of care coordination activities as specified in this Agreement, and who shall be the member's point of contact for coordination of all physical health, behavioral health, and long-term care services.
 - 2.9.6.4.3.1 For CHOICES members, who are, upon CHOICES enrollment, receiving services in a nursing facility or a community-based residential alternative setting, the CONTRACTOR shall assign a specific care coordinator prior to the first face-to-face visit required in this Agreement. If the first face-to-face visit will not

occur within the first ten (10) days of the member's enrollment in CHOICES, the CONTRACTOR shall send the member written notification within ten (10) calendar days of the member's enrollment that explains how the member can reach the care coordination unit for assistance with concerns or questions pending the assignment of a specific care coordinator.

2.9.6.4.3.2 For CHOICES members who, upon enrollment in CHOICES, are not receiving services in a nursing facility or a community-based residential alternative setting, the CONTRACTOR shall assign a specific care coordinator and shall advise the member of the name of his/her care coordinator and provide contact information prior to the initiation of services (see Sections 2.9.6.2.4.4, 2.9.6.2.5.3, and 2.9.6.3.17), but no more than ten (10) calendar days following CHOICES enrollment.

2.9.6.4.4 The CONTRACTOR may utilize a care coordination team approach to performing care coordination activities prescribed in Section 2.9.6. For each CHOICES member, the CONTRACTOR's care coordination team shall consist of the member's care coordinator and specific other persons with relevant expertise and experience appropriate to address the needs of CHOICES members. Care coordination teams shall be discrete entities within the CONTRACTOR's organizational structure dedicated to fulfilling CHOICES care coordination functions. The CONTRACTOR shall establish policies and procedures that specify, at a minimum: the composition of care coordination teams; the tasks that will be performed directly by the care coordinator; measures taken to ensure that the care coordinator remains the member's primary point of contact for the CHOICES program and related issues; escalation procedures to elevate issues to the care coordinator in a timely manner; and measures taken to ensure that if a member needs to reach his/her care coordinator specifically, calls that require immediate attention by a care coordinator are handled by a care coordinator and calls that do not require immediate attention are returned by the member's care coordinator the next business day.

2.9.6.5 Needs Assessment

2.9.6.5.1 *For Members in CHOICES Group 1*

2.9.6.5.1.1 As part of the face-to-face intake visit for current members or face-to-face visit with new members in CHOICES Group 1, as applicable, a care coordinator shall conduct any needs assessment deemed necessary by the CONTRACTOR, using a tool prior approved by TENNCARE and in accordance with protocols specified by TENNCARE. The care coordinator shall assess the member's potential for and interest in transition to the community and ensure coordination of the member's physical health, behavioral health, and long-term care needs. This assessment may include identification of targeted strategies related to improving health, functional, or quality of life outcomes (e.g., related to disease management or pharmacy management) or to increasing and/or maintaining functional abilities, including services covered by the CONTRACTOR that are beyond the scope of the nursing facility services benefit.

2.9.6.5.1.2 Needs reassessments shall be conducted as the care coordinator deems necessary.

2.9.6.5.2 *For Members in CHOICES Groups 2 and 3*

2.9.6.5.2.1 The care coordinator shall conduct a comprehensive needs assessment using a tool prior approved by TENNCARE and in accordance with protocols specified by TENNCARE as part of its face-to-face visit with new members in CHOICES Groups 2 and 3 (see Section 2.9.6.2.5) and as part of its face-to-face intake visit for current members applying for CHOICES Groups 2 and 3.

2.9.6.5.2.2 At a minimum, for members in CHOICES Group 2 and 3, the comprehensive needs assessment shall assess: (1) the member's physical, behavioral, functional, and psychosocial needs, including an evaluation of the member's financial health as it relates to the member's ability to maintain a safe and healthy living environment; (2) the member's natural supports, including care being provided by family members and/or other caregivers, and long-term care services the member is currently receiving (regardless of payor), and whether there is any anticipated change in the member's need for such care or services or the availability of such care or services from the current caregiver or payor; and (3) the physical health, behavioral health, and long-term care services and other social support services and assistance (e.g., housing or income assistance) that are needed, as applicable, to ensure the member's health safety and welfare in the community and to delay or prevent the need for institutional placement.

2.9.6.5.2.3 The comprehensive needs assessment shall be conducted at least annually and as the care coordinator deems necessary.

2.9.6.5.2.4 For CHOICES Group 2 and 3 members, the CONTRACTOR shall visit the member face-to-face within five (5) business days of becoming aware that the member has a significant change in needs or circumstances as defined in Section 2.9.6.9.2.1.16 The care coordinator shall assess the member's needs, conduct a comprehensive needs assessment and update the member's plan of care as deemed necessary based on the member's circumstances.

2.9.6.6 Plan of Care

2.9.6.6.1 *For Members in CHOICES Group 1*

2.9.6.6.1.1 For members in CHOICES Group 1, the member's care coordinator/care coordination team may: (1) rely on the plan of care developed by the nursing facility for service delivery instead of developing a plan of care for the member; and (2) supplement the nursing facility plan of care as necessary with the development and implementation of targeted strategies to improve health, functional, or quality of life outcomes (e.g., related to disease management or pharmacy management) or to increase and/or maintain functional abilities. A copy of any supplements to the nursing facility plan of care, and updates to such supplements, shall be maintained by the CONTRACTOR in the member's file.

2.9.6.6.1.2 The member's care coordinator shall participate as appropriate in the nursing facility's care planning process and advocate for the member.

2.9.6.6.1.3 The member's care coordinator/care coordination team shall be responsible for coordination of the member's physical health, behavioral health, and long-term

care needs, which shall include coordination with the nursing facility as necessary to facilitate access to physical health and/or behavioral health services needed by the member and to help ensure the proper management of the member's acute and/or chronic physical health or behavioral health conditions, including services covered by the CONTRACTOR that are beyond the scope of the nursing facility services benefit.

2.9.6.6.2 *For Members in CHOICES Groups 2 and 3*

2.9.6.6.2.1 For members in CHOICES Groups 2 and 3, the care coordinator shall coordinate and facilitate a care planning team that includes, at a minimum, the member and the member's care coordinator. As appropriate, the care coordinator shall include or seek input from other individuals such as the member's representative or other persons authorized by the member to assist with needs assessment and care planning activities.

2.9.6.6.2.2 The CONTRACTOR shall ensure that care coordinators consult with the member's PCP, specialists, behavioral health providers, other providers, and interdisciplinary team experts, as needed when developing the plan of care.

2.9.6.6.2.3 The care coordinator shall verify that the decisions made by the care planning team are documented in a written, comprehensive plan of care.

2.9.6.6.2.4 The plan of care developed for members in CHOICES Groups 2 and 3 prior to initiation of HCBS shall at a minimum include: (1) pertinent demographic information regarding the member including the name and contact information of any representative and a list of other persons authorized by the member to have access to health care (including long-term care) related information and to assist with assessment, planning, and/or implementation of health care (including long-term care) related services and supports; (2) care, including specific tasks and functions, that will be performed by family members and other caregivers; (3) home health, private duty nursing, and long-term care services the member will receive from other payor sources including the payor of such services; (4) home health and private duty nursing that will be authorized by the CONTRACTOR, except in the case of persons enrolled on the basis of Immediate Eligibility for CHOICES Group 2 who shall have access to services beyond the limited package of HCBS (see Section 2.6.1.5.3) only upon determination of categorical and financial eligibility for TennCare; (5) HCBS that will be authorized by the CONTRACTOR, including the amount, frequency, duration, and scope (tasks and functions to be performed) of each service to be provided, and the schedule at which such care is needed, as applicable; members enrolled on the basis of Immediate Eligibility for CHOICES Group 2 shall have access only to a limited package of HCBS (see Section 2.6.1.5.3) pending determination of categorical and financial eligibility for TennCare CHOICES however all identified needed services shall be listed in the plan of care; (6) a detailed back-up plan for situations when regularly scheduled HCBS providers are unavailable or do not arrive as scheduled; the back-up plan may include paid and unpaid supports and shall include the names and telephone numbers of persons and agencies to contact and the services provided by listed contacts; the CONTRACTOR shall assess the adequacy of the back-up plan; and (7) for CHOICES Group 2 members, the projected TennCare monthly and annual cost of home health and

private duty nursing identified in (4) above, and the projected monthly and annual cost of HCBS specified in (5) above, and for CHOICES Group 3 members, the projected total cost of HCBS specified in (5) above, excluding the cost of minor home modifications.

- 2.9.6.6.2.5 Within thirty (30) calendar days of notice of enrollment in CHOICES, for members in CHOICES Groups 2 and 3 the plan of care shall include, at a minimum, the following additional elements:
 - 2.9.6.6.2.5.1 Description of the member's current physical and behavioral health conditions and functional status (i.e., areas of functional deficit), and the member's physical, behavioral and functional needs;
 - 2.9.6.6.2.5.2 Description of the member's physical environment and any modifications necessary to ensure the member's health and safety;
 - 2.9.6.6.2.5.3 Description of medical equipment used or needed by the member (if applicable);
 - 2.9.6.6.2.5.4 Description of any special communication needs including interpreters or special devices;
 - 2.9.6.6.2.5.5 A description of the member's psychosocial needs, including any housing or financial assistance needs which could impact the member's ability to maintain a safe and healthy living environment;
 - 2.9.6.6.2.5.6 Goals, objectives and desired health, functional, and quality of life outcomes for the member;
 - 2.9.6.6.2.5.7 Description of other services that will be provided to the member, including (1) covered physical and behavioral health services that will be provided by the CONTRACTOR to help the member maintain or improve his or her physical or behavioral health status or functional abilities and maximize independence; (2) other social support services and assistance needed in order to ensure the member's health, safety and welfare, and as applicable, to delay or prevent the need for more expensive institutional placement; and (3) any non-covered services including services provided by other community resources, including plans to link the member to financial assistance programs including but not limited to housing, utilities and food as needed;
 - 2.9.6.6.2.5.8 Relevant information from the member's individualized treatment plan for any member receiving behavioral health services (see Section 2.7.2.1.4 of this Agreement) that is needed by a long-term care provider, caregiver or the care coordinator to ensure appropriate delivery of services or coordination of services;
 - 2.9.6.6.2.5.9 Relevant information regarding the member's physical health condition(s), including treatment and medication regimen, that is needed by a long-term care provider, caregiver or the care coordinator to ensure appropriate delivery of services or coordination of care;
 - 2.9.6.6.2.5.10 Frequency of planned care coordinator contacts needed, which shall include consideration of the member's individualized needs and circumstances, and

which shall at minimum meet required contacts as specified in Section 2.9.6.9.4 (unplanned care coordinator contacts shall be provided as needed);

- 2.9.6.6.2.5.11 Additional information for members who elect consumer direction of HCBS, including but not limited to whether the member requires a representative to participate in consumer direction and the specific services that will be consumer directed;
- 2.9.6.6.2.5.12 If the member chooses to self-direct any health care tasks, the type of tasks that will be self-directed;
- 2.9.6.6.2.5.13 Any steps the member and/or representative should take in the event of an emergency that differ from the standard emergency protocol;
- 2.9.6.6.2.5.14 A disaster preparedness plan specific to the member; and
- 2.9.6.6.2.5.15 The member's TennCare eligibility end date.
- 2.9.6.6.2.6 The member's care coordinator/care coordination team shall ensure that the member reviews, signs and dates the plan of care as well as any updates.
- 2.9.6.6.2.6.1 The CONTRACTOR shall develop policies and procedures that describe the measures taken by the CONTRACTOR to address instances when a member refuses to sign the plan of care. The policies and procedures shall include a specific escalation process (ultimately to TENNCARE) that includes a review of the reasons for the member's refusal as well as actions taken to resolve any disagreements with the plan of care and shall involve the consumer advocate in helping to facilitate resolution.
- 2.9.6.6.2.6.2 When the refusal to sign is due to a member's request for additional services, including requests for a different type or an increased amount, frequency, scope, and/or duration of services than what is included in the plan of care, the CONTRACTOR shall, in the case of a new plan of care, authorize and initiate services in accordance with the plan of care; and, in the case of an annual or revised plan of care, ensure continuation of at least the level of services in place at the time the annual or revised plan of care was developed until a resolution is reached, which may include resolution of a timely filed appeal, if applicable. The CONTRACTOR shall not use the member's acceptance of services as a waiver of the member's right to dispute the plan of care or as cause to stop the resolution process.
- 2.9.6.6.2.6.3 When the refusal to sign is due to the inclusion of services that the member does not want to receive, either in totality or in the amount, frequency, scope or duration of services in the plan of care, the care coordinator shall modify the risk agreement to note this issue, the associated risks, and the measures to mitigate the risks. The risk agreement shall be signed and dated by the member or his/her representative and the care coordinator. In the event the care coordinator determines that the member's needs cannot be safely and effectively met in the community without receiving these services, the CONTRACTOR may request that it no longer provide long-term care services to the member (see Section 2.6.1.5.8).

- 2.9.6.6.2.7 The member's care coordinator/care coordination team shall provide a copy of the member's completed plan of care, including any updates, to the member, the member's representative, as applicable, and the member's community residential alternative provider, as applicable. The member's care coordinator/care coordination team shall provide copies to other providers authorized to deliver care to the member upon request, and shall ensure that such providers who do not receive a copy of the plan of care are informed in writing of all relevant information needed to ensure the provision of quality care for the member and to help ensure the member's health, safety, and welfare, including but not limited to the tasks and functions to be performed.
- 2.9.6.6.2.8 Within five (5) business days of completing a reassessment of a member's needs, the member's care coordinator/care coordination team shall update the member's plan of care as appropriate, and the CONTRACTOR shall authorize and initiate HCBS in the updated plan of care. The CONTRACTOR shall comply with requirements for service authorization in Section 2.9.6.2.5.10, change of provider in Section 2.9.6.2.5.11, and notice of service delay in Section 2.9.6.2.5.12.
- 2.9.6.6.2.9 The member's care coordinator shall inform each member of his/her eligibility end date and educate members regarding the importance of maintaining TennCare CHOICES eligibility, that eligibility must be redetermined at least once a year, and that members will be contacted by TENNCARE or its designee near the date a redetermination is needed to assist them with the process, e.g., collecting appropriate documentation and completing the necessary forms.
- 2.9.6.7 Nursing Facility Diversion
- 2.9.6.7.1 As applicable, including when directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the CONTRACTOR shall develop and implement a nursing facility diversion process that complies with the requirements in this Section 2.9.6.7 and is prior approved in writing by TENNCARE. The diversion process shall not prohibit or delay a member's access to nursing facility services when these services are medically necessary and requested by the member.
- 2.9.6.7.2 At a minimum the CONTRACTOR's diversion process shall target the following groups for diversion activities:
- 2.9.6.7.2.1 Members in CHOICES Group 1 who are waiting for placement in a nursing facility;
- 2.9.6.7.2.2 CHOICES members residing in their own homes who have a negative change in circumstances and/or deterioration in health or functional status and who request nursing facility services;
- 2.9.6.7.2.3 CHOICES members residing in adult care homes or other community-based residential alternative settings who have a negative change in circumstances and/or deterioration in health or functional status and who request nursing facility services;

- 2.9.6.7.2.4 CHOICES and non-CHOICES members admitted to an inpatient hospital or inpatient rehabilitation who are not residents of a nursing facility; and
- 2.9.6.7.2.5 CHOICES and non-CHOICES members who are placed short-term in a nursing facility regardless of payer source.
- 2.9.6.7.3 The CONTRACTOR's nursing facility diversion process shall be tailored to meet the needs of each group identified in Section 2.9.6.7.2 above.
- 2.9.6.7.4 The CONTRACTOR's nursing facility diversion process shall include a detailed description of how the CONTRACTOR will work with providers (including hospitals regarding notice of admission and discharge planning; see Sections 2.9.6.3.4 and 2.9.6.3.11) to ensure appropriate communication among providers and between providers and the CONTRACTOR, training for key CONTRACTOR and provider staff, early identification of members who may be candidates for diversion (both CHOICES and non-CHOICES members), and follow-up activities to help sustain community living.
- 2.9.6.7.5 The CONTRACTOR's nursing facility diversion process shall include specific timelines for each identified activity.
- 2.9.6.8 Nursing Facility-to-Community Transition
 - 2.9.6.8.1 As applicable, including when directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the CONTRACTOR shall develop and implement methods for identifying members who may have the ability and/or desire to transition from a nursing facility to the community. Such methods shall include, at a minimum:
 - 2.9.6.8.1.1 Referrals, including but not limited to, treating physician, nursing facility, other providers, community-based organizations, family, and self-referrals;
 - 2.9.6.8.1.2 Identification through the care coordination process, including but not limited to: assessments, information gathered from nursing facility staff or participation in Grand Rounds (as defined in Section 1); and
 - 2.9.6.8.1.3 Upon notice from TENNCARE, review and analysis of members identified by TENNCARE based on Minimum Data Set (MDS) data from nursing facilities.
 - 2.9.6.8.2 For transition referrals by or on behalf of a nursing facility resident, regardless of referral source, the CONTRACTOR shall ensure that within fourteen (14) days of the referral the CONTRACTOR conducts an in-facility visit with the member to determine the member's interest in and potential ability to transition to the community, and provide orientation and information to the member regarding transition activities. The member's care coordinator/care coordination team shall document in the member's case file that transition was discussed with the member and indicate the member's wishes as well as the member's potential for transition. The CONTRACTOR shall not require a member to transition when the member expresses a desire to continue receiving nursing facility services.

- 2.9.6.8.3 For identification by the CONTRACTOR by means other than referral or the care coordination process of a member who may have the ability and/or desire to transition from a nursing facility to the community, the CONTRACTOR shall ensure that within ninety (90) days of such identification the CONTRACTOR conducts an in-facility visit with the member to determine whether or not the member is interested in and potential ability to pursue transition to the community. The member's care coordinator/care coordination team shall document in the member's case file that transition was discussed with the member and indicate the member's wishes as well as the member's potential for transition. The CONTRACTOR shall not require a member to transition when the member expresses a desire to continue receiving nursing facility services.
- 2.9.6.8.4 If the member wishes to pursue transition to the community, within fourteen (14) days of the initial visit (see Sections 2.9.6.8.2 and 2.9.6.8.3 above) or within fourteen (14) days of identification through the care coordination process, the care coordinator shall conduct an in-facility assessment of the member's ability and/or desire to transition using tools and protocols specified or prior approved in writing by TENNCARE. This assessment shall include the identification of any barriers to a safe transition.
- 2.9.6.8.5 As part of the transition assessment, the care coordinator shall conduct a risk assessment using a tool and protocol specified by TENNCARE, discuss with the member the risk involved in transitioning to the community and shall begin to develop, as applicable, a risk agreement that shall be signed by the member or his/her representative and which shall include identified risks to the member, the consequences of such risks, strategies to mitigate the identified risks, and the member's decision regarding his/her acceptance of risk as part of the plan of care. The risk agreement shall include the frequency and type of care coordinator contacts that exceed the minimum contacts required (see Section 2.9.6.9.4), to mitigate any additional risks associated with transition and shall address any special circumstances due to transition. The member's care coordinator/care coordination team shall also make a determination regarding whether the member's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care. The member's care coordinator/care coordination team shall explain to the member the individual cost neutrality cap and notification process and obtain a signed acknowledgement of understanding by the member or his/her representative that a change in a member's needs or circumstances that would result in the cost neutrality cap being exceeded or that would result in the CONTRACTOR's inability to safely and effectively meet a member's needs in the community and within the cost neutrality cap may result in the member's disenrollment from CHOICES Group 2, in which case, the CONTRACTOR will assist with transition to a more appropriate care delivery setting.
- 2.9.6.8.6 For those members whose transition assessment indicates that they are not candidates for transition to the community, the care coordinator shall notify them in accordance with the specified transition assessment protocol.
- 2.9.6.8.7 For those members whose transition assessment indicates that they are candidates for transition to the community, the care coordinator shall facilitate the development of and complete a transition plan within fourteen (14) days of the member's transition assessment.

- 2.9.6.8.8 The care coordinator shall include other individuals such as the member's family and/or caregiver in the transition planning process if the member requests and/or approves, and such persons are willing and able to participate.
- 2.9.6.8.9 As part of transition planning, prior to the member's physical move to the community, the care coordinator shall visit the residence where the member will live to conduct an on-site evaluation of the physical residence and meet with the member's family or other caregiver who will be residing with the member (as appropriate). The care coordinator shall include in the transition plan activities and/or services needed to mitigate any perceived risks in the residence including but not limited to an increase in face-to-face visits beyond the minimum required contacts in Sections 2.9.6.8.18 and 2.9.6.8.17.
- 2.9.6.8.10 The transition plan shall address all services necessary to safely transition the member to the community and include at a minimum member needs related to housing, transportation, availability of caregivers, and other transition needs and supports. The transition plan shall also identify any barriers to a safe transition and strategies to overcome those barriers.
- 2.9.6.8.11 The CONTRACTOR shall approve the transition plan and authorize any covered or cost effective alternative services included in the plan within ten (10) business days of completion of the plan. The transition plan shall be fully implemented within ninety (90) days from approval of the transition plan, except under extenuating circumstances which must be documented in writing.
- 2.9.6.8.12 The member's care coordinator shall also complete a plan of care that meets all criteria described in Section 2.9.6.6 for members in CHOICES Groups 2 and 3 including but not limited to completing a comprehensive needs assessment, completing and signing the risk agreement and making a final determination of cost neutrality. The plan of care shall be authorized and initiated prior to the member's transition to the community.
- 2.9.6.8.13 The CONTRACTOR shall not prohibit a member from transitioning to the community once the member has been counseled regarding risk. However, the CONTRACTOR may determine that the member's needs cannot be safely and effectively met in the community and at a cost that does not exceed nursing facility care. In such case, the CONTRACTOR shall seek written review and approval from TENNCARE prior to denial of any member's request to transition to the community. If TENNCARE approves the CONTRACTOR's request, the CONTRACTOR shall notify the member in accordance with TennCare rules and regulations and the transition assessment protocol, and the member shall have the right to appeal the determination (see Section 2.19.3.12 of this Agreement).
- 2.9.6.8.14 Once completed, the CONTRACTOR shall submit to TENNCARE documentation, as specified by TENNCARE to verify that the member's needs can be safely and effectively met in the community and within the cost neutrality cap. Before transitioning a member the CONTRACTOR shall verify that the member has been approved for enrollment in CHOICES Group 2 effective as of the planned transition date.

- 2.9.6.8.15 The member's care coordinator shall monitor all aspects of the transition process and take immediate action to address any barriers that arise during transition.
- 2.9.6.8.16 For members transitioning to a setting other than a community-based residential alternative setting, the care coordinator shall upon transition utilize the EVV system to monitor the initiation and daily provision of services in accordance with the member's new plan of care, and shall take immediate action to resolve any service gaps (see definition in Section 1).
- 2.9.6.8.17 For members who will live independently in the community or whose on-site visit during transition planning indicated an elevated risk, within the first twenty-four (24) hours, the care coordinator shall visit the member in his/her residence. During the initial ninety (90) day post-transition period, the care coordinator shall conduct monthly face-to-face in-home visits to ensure that the plan of care is being followed, that the plan of care continues to meet the member's needs, and the member has successfully transitioned to the community.
- 2.9.6.8.18 For members transitioning to a community-based residential alternative setting or who will live with a relative or other caregiver, within the first twenty-four (24) hours the care coordinator shall contact the member and within seven (7) days after the member has transitioned to the community, the care coordinator shall visit the member in his/her new residence. During the initial ninety (90) day post-transition period, the care coordinator shall (1) at a minimum, contact the member by telephone each month to ensure that the plan of care is being followed, that the plan of care continues to meet the member's needs, and the member has successfully transitioned to the community; and (2) conduct additional face-to-face visits as necessary to address issues and/or concerns and to ensure that the member's needs are met.
- 2.9.6.8.19 The member's care coordinator shall monitor hospitalizations and short-term nursing facility stays for members who transition to identify and address issues that may prevent the member's long-term community placement.
- 2.9.6.8.20 The CONTRACTOR shall monitor hospitalizations and nursing facility re-admission for members who transition from a nursing facility to the community to identify issues and implement strategies to improve transition outcomes.
- 2.9.6.8.21 The CONTRACTOR shall be permitted to coordinate or subcontract with local community-based organizations to assist in the identification, planning and facilitation processes related to nursing facility-to-community transitions.
- 2.9.6.8.22 The CONTRACTOR shall develop and implement any necessary assessment tools, transition plan templates, protocols, or training necessary to ensure that issues that may hinder a member's successful transition are identified and addressed. Any tool, template, or protocol must be prior approved in writing by TENNCARE.
- 2.9.6.9 Ongoing Care Coordination
- 2.9.6.9.1 *For Members in CHOICES Group 1*
- 2.9.6.9.1.1 The CONTRACTOR shall provide for the following ongoing care coordination to members in CHOICES Group 1:

- 2.9.6.9.1.1.1 Develop protocols and processes to work with nursing facilities to coordinate the provision of care. At minimum, a care coordinator assigned to a resident of the nursing facility shall participate in quarterly Grand Rounds (as defined in Section 1). At least two of the Grand Rounds per year shall be conducted on-site in the facility, and the Grand Rounds shall identify and address any member who has experienced a potential significant change in needs or circumstances (see Section 2.9.6.9.1.1.5) or about whom the nursing facility or MCO has expressed concerns;
- 2.9.6.9.1.1.2 Develop and implement targeted strategies to improve health, functional, or quality of life outcomes, e.g., related to disease management or pharmacy management, or to increase and/or maintain functional abilities;
- 2.9.6.9.1.1.3 Coordinate with the nursing facility as necessary to facilitate access to physical health and/or behavioral health services needed by the member and to help ensure the proper management of the member's acute and/or chronic health conditions, including services covered by the CONTRACTOR that are beyond the scope of the nursing facility services benefit;
- 2.9.6.9.1.1.4 Intervene and address issues as they arise regarding payment of patient liability amounts and assist in interventions to address untimely or non-payment of patient liability in order to avoid the consequences of non-payment; and
- 2.9.6.9.1.1.5 At a minimum, the CONTRACTOR shall consider the following a potential significant change in needs or circumstances for CHOICES Group 1 members who are residing in a nursing facility and contact the nursing facility to determine if a visit and reassessment is needed:
 - 2.9.6.9.1.1.5.1 Pattern of recurring falls;
 - 2.9.6.9.1.1.5.2 Incident, injury or complaint;
 - 2.9.6.9.1.1.5.3 Report of abuse or neglect;
 - 2.9.6.9.1.1.5.4 Frequent hospitalizations; or
 - 2.9.6.9.1.1.5.5 Prolonged or significant change in health and/or functional status.
- 2.9.6.9.2 *For Members in CHOICES Groups 2 and 3*
 - 2.9.6.9.2.1 The CONTRACTOR shall provide for the following ongoing care coordination to members in CHOICES Groups 2 and 3:
 - 2.9.6.9.2.1.1 Coordinate a care planning team, developing a plan of care and updating the plan as needed;
 - 2.9.6.9.2.1.2 During the development of the member's plan of care and as part of the annual updates, the care coordinator shall discuss with the member his/her interest in consumer direction of HCBS;

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- 2.9.6.9.2.1.3 During the development of the member's plan of care, the care coordinator shall educate the member about his/her ability to use advance directives and document the member's decision in the member's file;
- 2.9.6.9.2.1.4 Ensure the plan of care addresses the member's desired outcomes, needs and preferences;
- 2.9.6.9.2.1.5 For members in CHOICES Group 2, each time a member's plan of care is updated to change the level or type of service, document in accordance with TENNCARE policy that the projected total cost of HCBS, home health care and private duty nursing is less than the member's cost neutrality cap. The CONTRACTOR shall monitor utilization to identify members who may exceed the cost neutrality cap and to intervene as necessary to maintain the member's community placement. The CONTRACTOR shall also educate members in CHOICES Group 2 about the cost neutrality cap and what will happen if the cap is met;
- 2.9.6.9.2.1.6 For members in CHOICES Group 3, determine whether the cost of HCBS, excluding minor home modifications, will exceed the expenditure cap for CHOICES Group 3. The CONTRACTOR shall continuously monitor a member's expenditures and work with the member when he/she is approaching the limit including identifying non-long term care services that will be provided when the limit has been met to prevent/delay the need for institutionalization. Each time the plan of care for a member in CHOICES Group 3 is updated, the CONTRACTOR shall educate the member about the expenditure cap;
- 2.9.6.9.2.1.7 For new services in an updated plan of care, the care coordinator shall provide the member with information about potential providers for each HCBS that will be provided by the CONTRACTOR and assist members with any requests for information that will help the member in choosing a provider and, if applicable, in changing providers, subject to the provider's capacity and willingness to provide service;
- 2.9.6.9.2.1.8 Upon the scheduled initiation of services identified in the plan of care, the member's care coordinator/care coordination team shall begin monitoring to ensure that services have been initiated and continue to be provided as authorized. This shall include ongoing monitoring via electronic visit verification to ensure that services are provided in accordance with the member's plan of care, including the amount, frequency, duration and scope of each service, in accordance with the member's service schedule; and that services continue to meet the member's needs;
- 2.9.6.9.2.1.9 Identify and address service gaps, ensure that back-up plans are implemented and effectively working, and evaluate service gaps to determine their cause and to minimize gaps going forward. The CONTRACTOR shall describe in policies and procedures the process for identifying, responding to, and resolving service gaps in a timely manner;
- 2.9.6.9.2.1.10 Identify changes to member's risk, address those changes and update the member's risk agreement as necessary;

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- 2.9.6.9.2.1.11 Reassess a member's needs and update a member's plan of care in accordance with requirements and timelines specified Sections 2.9.6.5 and 2.9.6.6;
- 2.9.6.9.2.1.12 Maintain appropriate on-going communication with community and natural supports to monitor and support their ongoing participation in the member's care;
- 2.9.6.9.2.1.13 For services not covered by the CONTRACTOR, coordinate with community organizations that provide services that are important to the health, safety and well-being of members. This may include but shall not be limited to referrals to other agencies for assistance and assistance as needed with applying for programs, but the CONTRACTOR shall not be responsible for the provision or quality of non-covered services provided by other entities;
- 2.9.6.9.2.1.14 Notify TENNCARE immediately, in the manner specified by TENNCARE, if the CONTRACTOR determines that the needs of a member in CHOICES Group 2 cannot be met safely in the community and within the member's cost neutrality cap;
- 2.9.6.9.2.1.15 Perform additional requirements for consumer direction of HCBS as specified in Section 2.9.6.10; and
- 2.9.6.9.2.1.16 At a minimum, the CONTRACTOR shall consider the following a significant change in needs or circumstances for members in CHOICES Groups 2 and 3 residing in the community:
 - 2.9.6.9.2.1.16.1 Change of residence or primary caregiver or loss of essential social supports;
 - 2.9.6.9.2.1.16.2 Significant change in health and/or functional status;
 - 2.9.6.9.2.1.16.3 Loss of mobility;
 - 2.9.6.9.2.1.16.4 An event that significantly increases the perceived risk to a member; or
 - 2.9.6.9.2.1.16.5 Member has been referred to APS because of abuse, neglect or exploitation.
- 2.9.6.9.2.1.17 Identify and immediately respond to problems and issues including but not limited to circumstances that would impact the member's ability to continue living in the community.
- 2.9.6.9.3 *For ALL CHOICES Members*
 - 2.9.6.9.3.1 The CONTRACTOR shall provide for the following ongoing care coordination to all CHOICES members:
 - 2.9.6.9.3.1.1 Conduct a level of care reassessment at least annually and within five (5) business days of the CONTRACTOR's becoming aware that the member's functional or medical status has changed in a way that may affect level of care eligibility.
 - 2.9.6.9.3.1.1.1 If the level of care assessment indicates a change in the level of care or if the assessment was prompted by a request by a member, a member's

representative or caregiver or another entity for a change in level of services, the assessment shall be forwarded to TENNCARE for determination;

- 2.9.6.9.3.1.1.2 If the level of care assessment indicates no change in level of care, the CONTRACTOR shall document the date the level of care assessment completed in the member's file; any level of care assessments prompted by a request for a change in level of services shall be submitted to TENNCARE for determination.
- 2.9.6.9.3.1.2 Facilitate access to physical and/or behavioral health services as needed, including transportation to services as specified in Section 2.6.1 and Attachment XI; except as provided in Sections 2.11.1.8 or 2.6.5, transportation for HCBS is not included;
- 2.9.6.9.3.1.3 Monitor and ensure the provision of covered physical health, behavioral health, and/or long-term care services as well as services provided as a cost-effective alternative to other covered services and ensure that services provided meet the member's needs;
- 2.9.6.9.3.1.4 Provide assistance in resolving concerns about service delivery or providers;
- 2.9.6.9.3.1.5 Coordinate with a member's PCP, specialists and other providers, such as the member's mental health case manager, to facilitate a comprehensive, holistic, person-centered approach to care;
- 2.9.6.9.3.1.6 Contact providers and workers on a periodic basis and coordinate with providers and workers to collaboratively address issues regarding member service delivery and to maximize community placement strategies;
- 2.9.6.9.3.1.7 Share relevant information with and among providers and others when information is available and it is necessary to share for the well-being of the member;
- 2.9.6.9.3.1.8 Determine the appropriate course as specified herein upon (1) receipt of any contact made by or on behalf of a member, regardless of source, which asserts that the member's needs are not met by currently authorized services; (2) the member's hospitalization; or (3) other circumstances which warrant review and potential modification of services authorized for the member;
- 2.9.6.9.3.1.9 Ensure that all PASRR requirements are met prior to the member's admission to a nursing facility;
- 2.9.6.9.3.1.10 Update consent forms as necessary; and
- 2.9.6.9.3.1.11 Assure that the organization of and documentation included in the member's file meets all applicable CONTRACTOR standards.
- 2.9.6.9.3.2 The CONTRACTOR shall provide to contract providers, including but not limited to hospitals, nursing facilities, physicians, and behavioral health providers, and caregivers information regarding the role of the care coordinator and shall request providers and caregivers to notify a member's care coordinator,

as expeditiously as warranted by the member's circumstances, of any significant changes in the member's condition or care, hospitalizations, or recommendations for additional services. The CONTRACTOR shall provide training to key providers and caregivers regarding the value of this communication and remind them that the member identification card indicates if a member is enrolled in CHOICES.

- 2.9.6.9.3.3 The CONTRACTOR shall have systems in place to facilitate timely communication between internal departments and the care coordinator to ensure that each care coordinator receives all relevant information regarding his/her members, e.g., member services, disease management, utilization management, and claims processing. The care coordinator shall follow-up on this information as appropriate, e.g., documentation in the member's plan of care, monitoring of outcomes, and, as appropriate, needs reassessment and updating the plan of care.
- 2.9.6.9.3.4 The CONTRACTOR shall monitor and evaluate a member's emergency department and behavioral health crisis service utilization to determine the reason for these visits. The care coordinator shall take appropriate action to facilitate appropriate utilization of these services, e.g., communicating with the member's providers, educating the member, conducting a needs reassessment, and/or updating the member's plan of care and to better manage the member's physical health or behavioral health condition(s).
- 2.9.6.9.3.5 The CONTRACTOR shall develop policies and procedures to ensure that care coordinators are actively involved in discharge planning when a CHOICES member is hospitalized. The CONTRACTOR shall define circumstances that require that hospitalized CHOICES members receive a face-to-face visit to complete a needs reassessment and an update to the member's plan of care as needed.
- 2.9.6.9.3.6 The CONTRACTOR shall ensure that at each face-to-face visit the care coordinator makes the following observations and documents the observations in the member's file:
 - 2.9.6.9.3.6.1 Member's physical condition including observations of the member's skin, weight changes and any visible injuries;
 - 2.9.6.9.3.6.2 Member's physical environment;
 - 2.9.6.9.3.6.3 Member's satisfaction with services and care;
 - 2.9.6.9.3.6.4 Member's upcoming appointments;
 - 2.9.6.9.3.6.5 Member's mood and emotional well-being;
 - 2.9.6.9.3.6.6 Member's falls and any resulting injuries;
 - 2.9.6.9.3.6.7 A statement by the member regarding any concerns or questions; and
 - 2.9.6.9.3.6.8 A statement from the member's representative or caregiver regarding any concerns or questions (when the representative/caregiver is available).

- 2.9.6.9.3.7 The CONTRACTOR shall identify and immediately respond to problems and issues including but not limited to:
 - 2.9.6.9.3.7.1 Service gaps; and
 - 2.9.6.9.3.7.2 Complaints or concerns regarding the quality of care rendered by providers, workers, or care coordination staff.
- 2.9.6.9.4 *Minimum Care Coordinator Contacts*
 - 2.9.6.9.4.1 The care coordinator shall conduct all needs assessment and care planning activities, and shall make all minimum care coordinator contacts as specified below in the member's place of residence, except under extenuating circumstances (such as assessment and care planning conducted during the member's hospitalization, or upon the member's request), which shall be documented in writing.
 - 2.9.6.9.4.1.1 While the CONTRACTOR may grant a member's request to conduct certain care coordination activities outside his or her place of residence, the CONTRACTOR is responsible for assessing the member's living environment in order to identify any modifications that may be needed and to identify and address, on an ongoing basis, any issues which may affect the member's health, safety and welfare. Repeated refusal by a member in CHOICES Group 2 or 3 to allow the care coordinator to conduct visits in his or her home may, subject to review and approval by TENNCARE, constitute grounds for disenrollment from CHOICES Groups 2 or 3, if the CONTRACTOR is unable to properly perform monitoring and other contracted functions and to confirm that the member's needs can be safely and effectively met in the home setting.
 - 2.9.6.9.4.2 A member may initiate a request to opt out of some of the minimum face-to-face contacts, but only with TENNCARE review of circumstances and approval. The CONTRACTOR shall not encourage a member to request a reduction in face-to-face visits by the care coordinator.
 - 2.9.6.9.4.3 The CONTRACTOR shall ensure that care coordinators assess each member's need for contact with the care coordinator, to meet the member's individual need and ensure the member's health and welfare. At a minimum, CHOICES members shall be contacted by their care coordinator according to the following timeframes:
 - 2.9.6.9.4.3.1 Members shall receive a face-to-face visit from their care coordinator in their residence within the timeframes specified in Sections 2.9.6.2.4, 2.9.6.2.5 and 2.9.6.3.
 - 2.9.6.9.4.3.2 Members who are newly admitted to a nursing facility when the admission has not been authorized by the CONTRACTOR, shall receive a face-to-face visit from their care coordinator within ten (10) days of notification of admission.

- 2.9.6.9.4.3.3 Members in CHOICES Group 2 who have transitioned from a nursing facility to the community shall be contacted per the applicable timeframe specified in Section 2.9.6.8.
- 2.9.6.9.4.3.4 Within five (5) business days of scheduled initiation of services, the member's care coordinator/care coordination team shall contact members in CHOICES Groups 2 and 3 who begin receiving HCBS after the date of enrollment in CHOICES to confirm that services are being provided and that the member's needs are being met (such initial contact may be conducted by phone).
- 2.9.6.9.4.3.5 Within five (5) business days of scheduled initiation of HCBS in the updated plan of care, the member's care coordinator/care coordination team shall contact members in CHOICES Groups 2 and 3 to confirm that services are being provided and that the member's needs are being met (such initial contact may be conducted by phone).
- 2.9.6.9.4.3.6 Members in CHOICES Group 1 (who are residents of a nursing facility) shall receive a face-to-face visit from their care coordinator at least twice a year at a reasonable interval.
- 2.9.6.9.4.3.7 Members in CHOICES Group 2 shall be contacted by their care coordinator at least monthly either in person or by telephone. These members shall be visited in their residence face-to-face by their care coordinator at least quarterly.
- 2.9.6.9.4.3.8 Members in CHOICES Group 3 shall be contacted by their care coordinator at least quarterly either in person or by telephone. These members shall be visited in their residence face-to-face by their care coordinator a minimum of semi-annually.
- 2.9.6.9.5 The CONTRACTOR shall ensure a member's care coordinator/care coordination team coordinates with Medicare payers, Medicare Advantage plans, and Medicare providers as appropriate to coordinate the care and benefits of members who are also eligible for Medicare (see Section 2.9.12).
- 2.9.6.9.6 *Member Case Files*
 - 2.9.6.9.6.1 The care coordinator/care coordination team shall maintain individual files for each assigned CHOICES member.
 - 2.9.6.9.6.2 For members in CHOICES Group 1, the files shall contain at a minimum:
 - 2.9.6.9.6.2.1 Pertinent demographic information regarding the member including the name and contact information of any representative and a list of other persons authorized by the member to have access to health care (including long-term care) related information;
 - 2.9.6.9.6.2.2 Any supplements to the nursing facility plan of care, as applicable;
 - 2.9.6.9.6.2.3 A signed acknowledgement of the member's patient liability amount and the member's understanding regarding his/her responsibility with respect to payment of patient liability, including the potential consequences for non-payment; and

- 2.9.6.9.6.2.4 Transition assessment and transition plan, if applicable.
- 2.9.6.9.6.3 For members in CHOICES Groups 2 or 3, the files shall contain at a minimum:
 - 2.9.6.9.6.3.1 The most current plan of care, including the detailed plan for back-up providers in situations when regularly scheduled providers are unavailable or do not arrive as scheduled;
 - 2.9.6.9.6.3.2 List of providers who will be providing home health, private duty nursing and HCBS paid for by other payors;
 - 2.9.6.9.6.3.3 Written confirmation of the member's decision regarding participation in consumer direction of HCBS;
 - 2.9.6.9.6.3.4 For members who are self-directing any health care tasks, a copy of the physician's order;
 - 2.9.6.9.6.3.5 For members in CHOICES Group 2, a completed risk assessment and a risk agreement signed by the member or his/her representative; and documentation that the person's needs can be safely and effectively met in the community and at a cost that does not exceed nursing facility care, including signed acknowledgement of understanding by the member or his/her representative that a change in needs or circumstances that would result in the cost neutrality cap being exceeded or that would result in the CONTRACTOR's inability to safely and effectively meet the member's needs in the community and within the cost neutrality cap may result in the member's disenrollment from CHOICES Group 2;
 - 2.9.6.9.6.3.6 For members in CHOICES Group 2, the cost neutrality cap provided by TENNCARE, a determination by the CONTRACTOR that the projected cost of HCBS, home health, and private duty nursing services will not exceed the member's cost neutrality cap, and signed acknowledgement of understanding by the member or his/her representative that a change in his/her needs or circumstances that would result in the cost neutrality cap being exceeded or that would result in the MCO's inability to safely and effectively meet a member's needs in the community and within the cost neutrality cap may result in the member's disenrollment from CHOICES Group 2 ; and
 - 2.9.6.9.6.3.7 For members in CHOICES Group 3, signed acknowledgement regarding the expenditure cap.
- 2.9.6.9.6.4 For all CHOICES members, files shall contain at a minimum:
 - 2.9.6.9.6.4.1 For CHOICES members in CHOICES Group 1 and Group 2, Freedom of Choice form signed by the member or his/her representative; this requirement shall only apply to persons age 21 and older who may qualify to enroll in CHOICES Groups 2 or 3;

- 2.9.6.9.6.4.2 Evidence that a care coordinator/the care coordination team provided the member with CHOICES member education materials (see Section 2.17.7 of this Agreement), reviewed the materials, and provided assistance with any questions;
 - 2.9.6.9.6.4.3 Evidence that a care coordinator/the care coordination team provided the member with education about the member's ability to use an advance directive and documentation of the member's decision;
 - 2.9.6.9.6.4.4 The most recent level of care assessment and needs assessment (if applicable);
 - 2.9.6.9.6.4.5 Documentation of the member's choice of contract providers for long-term care services;
 - 2.9.6.9.6.4.6 Signed consent forms as necessary in order to share confidential information with and among providers consistent with all applicable state and federal laws and regulations;
 - 2.9.6.9.6.4.7 A list of emergency contacts approved by the member;
 - 2.9.6.9.6.4.8 Documentation of observations completed during face-to-face contact by the care coordinator; and
 - 2.9.6.9.6.4.9 The member's TennCare eligibility end date.
- 2.9.6.10 Additional Requirements for Care Coordination Regarding Consumer Direction of HCBS
- 2.9.6.10.1 In addition to the roles and responsibilities otherwise specified in this Section 2.9.6, the CONTRACTOR shall ensure that the following additional care coordination functions related to consumer direction of HCBS are fulfilled (see Section 2.9.7). As provided in Section 2.9.7, only members in CHOICES Group 2 or 3 may participate in consumer direction of HCBS. Therefore, requirements regarding consumer direction of HCBS will not apply to the CONTRACTOR unless and until the CONTRACTOR is directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3. When directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the CONTRACTOR shall, as directed by TENNCARE, comply with all the requirements in Section 2.9.6.10.
 - 2.9.6.10.2 The CONTRACTOR shall be responsible for providing all needed eligible HCBS using contract providers until all necessary requirements have been fulfilled in order to implement consumer direction of HCBS, including but not limited to: the FEA verifies that workers for these services meet all necessary requirements (see Section 2.9.7.6.1 of this Agreement); service agreements are completed and signed; and authorizations for consumer directed services are in place. The CONTRACTOR, in conjunction with the FEA, shall facilitate a seamless transition between contract providers and workers and ensure that there are no interruptions or gaps in services.
 - 2.9.6.10.3 If a member is interested in participating in consumer direction of HCBS and the member does not intend to appoint a representative, the care coordinator shall determine the extent to which the member may require assistance to direct his/her

services (see Section 2.9.7.4.5). If the care coordinator determines that the member requires assistance to direct his/her services, based upon the results of a completed self-assessment instrument developed by TENNCARE, the care coordinator shall inform the member that he/she will need to designate a representative to assume the consumer direction functions on his/her behalf (see Section 2.9.7.4.5.1).

- 2.9.6.10.4 The member's care coordinator/care coordination team shall ensure that the person identified to serve as the representative meets all qualifications (see Section 2.9.7.2.1) and that a representative agreement is completed and signed by the member prior to forwarding a referral to the FEA (see Section 2.9.7.4.7).
- 2.9.6.10.5 For members electing to participate in consumer direction, forward to the FEA a referral initiating the member's participation in consumer direction of HCBS: (1) within two (2) business days of signing the representative agreement; or (2) if a representative is not designated by the member, within two (2) business days of completion of the self-assessment instrument and the care coordinator determines that the member does not require a representative to assist the member in directing his/her care.
- 2.9.6.10.6 For members electing to participate in consumer direction, the member's care coordinator shall integrate the member's back-up plan for consumer-directed workers (including any updates thereto) into the member's back-up plan for services provided by contract providers, as applicable, and the member's plan of care. The care coordinator shall review the back-up plan developed by the member or his/her representative (as applicable) for consumer direction to determine its adequacy to address the member's needs, and shall monitor for late and missed visits and to ensure that the back-up plan was implemented timely and that the member's needs are being met.
- 2.9.6.10.7 For members electing to participate in consumer direction, the member's care coordinator shall reassess the adequacy of the member's back-up plan for consumer direction on at least an annual basis which shall include any time there are changes in the type, amount, duration, scope of eligible HCBS or the schedule at which such services are needed, changes in consumer-directed workers (when such workers also serve as a back-up to other workers) or changes in the availability of paid or unpaid back-up workers to deliver needed care
- 2.9.6.10.8 For members electing to participate in consumer direction, the member's care coordinator shall develop and/or update, as applicable, a risk agreement which takes into account the member's decision to participate in consumer direction, and which identifies any additional risks associated with the member's decision to direct his/her services, the potential consequences of such risk, as well as measures to mitigate these risks. The member's representative (if applicable) shall participate in the risk assessment process. The new or updated risk agreement, as applicable, shall be signed by the care coordinator and the member (or the member's representative, as applicable). The CONTRACTOR shall provide a copy of the risk agreement to the member/representative and the FEA.
- 2.9.6.10.9 On an ongoing basis, the CONTRACTOR shall ensure that needs reassessments and updates to the plan of care occur per requirements specified in Sections 2.9.6.9 of this Agreement. The care coordinator shall ensure that, for members participating in

consumer direction, the member's supports broker is invited to participate in these meetings.

- 2.9.6.10.10 Within two (2) business days of receipt of the notification from the FEA indicating that all requirements have been fulfilled and the date that the consumer direction can begin for a member, the CONTRACTOR shall forward to the FEA an authorization for consumer directed services for that member. Each authorization for consumer directed services shall include authorized service, authorized units of service, including amount, frequency and duration and the schedule at which services are needed, start and end dates, and service code(s).
- 2.9.6.10.11 The member's care coordinator/care coordination team shall work with and coordinate with a member's supports broker in implementing and monitoring consumer direction of HCBS (see Section 2.9.7.3.4).
- 2.9.6.10.12 The CONTRACTOR shall establish a process that allows for the efficient exchange of all relevant member information between the CONTRACTOR and the FEA.
- 2.9.6.10.13 The care coordinator shall determine a member's interest in enrolling in or continuing to participate in consumer direction annually and shall document the member's decision in the member's plan of care.
- 2.9.6.10.14 If at anytime abuse or neglect is suspected, the member's care coordinator or the FEA shall report the allegations to the CONTRACTOR within 24 hours in accordance with the CONTRACTOR's abuse and neglect plan protocols. The notification shall include at a minimum: the member name; date of allegation reported and/or identified; description of issue; measures taken to mitigate risk; status of reporting to CPS or APS, as appropriate. If the allegation is in reference to a worker or representative, the FEA shall contact the member/representative to immediately release the worker or representative from his/her duties until the investigation is complete. The FEA shall notify the CONTRACTOR regarding this communication with the member/representative and the member or representative's decision. The care coordinator shall work the member to find a new representative and the FEA shall work with the member to find a suitable replacement worker, if applicable. If the allegations are substantiated as a result of the investigation, the representative and/or worker shall no longer be allowed to participate in the CHOICES program in any capacity. If the investigation is inconclusive, the member may elect to retain the worker or representative. The member's care coordinator, with appropriate assistance from the FEA, shall make any updates to the member's plan of care and/or risk assessment/risk agreement deemed necessary to help ensure the member's health and safety, and the CONTRACTOR may initiate action to involuntary disenroll the member from consumer direction at any time the CONTRACTOR feels that the member's decisions or actions constitute unreasonable risk such that the member's needs can no longer be safely and effectively met in the community while participating in consumer direction.
- 2.9.6.11 Care Coordination Staff
- 2.9.6.11.1 The CONTRACTOR shall establish qualifications for care coordinators. At a minimum, care coordinators shall be an RN or LPN or have a bachelor's degree in social work, nursing or other health care profession. A care coordinator's direct

supervisor shall be a licensed social worker or registered nurse with a minimum of two (2) years of relevant health care (preferably long-term care) experience.

- 2.9.6.11.2 If the CONTRACTOR elects to use a care coordination team, the CONTRACTOR's policies and procedures shall specify the qualifications, experience and training of each member of the team and ensure that functions specific to the assigned care coordinator are performed by a qualified care coordinator (see Section 2.9.6.4.4).
- 2.9.6.11.3 The CONTRACTOR shall ensure an adequate number of care coordinators are available and that sufficient staffing ratios are maintained to address the needs of CHOICES members and meet all the requirements described in this Agreement.
- 2.9.6.11.4 The CONTRACTOR shall monitor staffing ratios and adjust ratios as necessary to ensure that care coordinators are able to meet the requirements of this Agreement and address members' needs.
- 2.9.6.11.5 While care coordination staffing ratios are not specified, the CONTRACTOR shall submit to TENNCARE for review and approval at least 120 days in advance of CHOICES implementation in each Grand Region a Care Coordination Staffing Plan, which shall specify the number of care coordinators, care coordination supervisors, other care coordination team members the CONTRACTOR plans to initially employ, the ratio of care coordinators to members the CONTRACTOR plans to maintain, an explanation of the methodology for determining such ratio, and how the CONTRACTOR will ensure that such ratios are sufficient to fulfill the requirements specified in this Agreement and roles and responsibilities for each member of the care coordination team. TENNCARE shall notify the CONTRACTOR in writing if the Care Coordination Staffing Plan is insufficient and may require modifications to ensure, prior to implementation of CHOICES in each Grand Region, that the CONTRACTOR has sufficient care coordination staff. After CHOICES has been implemented, the CONTRACTOR shall notify TENNCARE in writing of substantive changes to its Care Coordination Staffing Plan, including a variance of twenty (20) percent or more from the planned staffing ratio. TENNCARE may request changes in the CONTRACTOR's Care Coordination Staffing Plan at any time it determines that the CONTRACTOR does not have sufficient care coordination staff to properly and timely perform its obligations under this Agreement.
- 2.9.6.11.6 The CONTRACTOR shall establish a system to assign care coordinators and to notify the member of his/her assigned care coordinator's name and contact information in accordance with Section 2.9.6.4.3.
- 2.9.6.11.7 The CONTRACTOR shall ensure that members have a telephone number to call to directly contact (without having to disconnect or place a second call) their care coordinator or a member of their care coordination team (if applicable) during normal business hours. If the member's care coordinator or a member of the member's care coordination team is not available, the call shall be answered by another qualified staff person in the care coordination unit. If the call requires immediate attention from a care coordinator, the staff member answering the call shall immediately transfer the call to the member's care coordinator (or another care coordinator if the member's care coordinator is not available) as a "warm transfer" (see definition in Section 1). After normal business hours, calls that require immediate attention by a

care coordinator shall be transferred to a care coordinator as specified in Section 2.18.1.6.

- 2.9.6.11.8 The CONTRACTOR shall permit members to change to a different care coordinator if the member desires and there is an alternative care coordinator available. Such availability may take into consideration the CONTRACTOR's need to efficiently deliver care coordination in accordance with requirements specified herein, including for example, the assignment of a single care coordinator to all CHOICES members receiving nursing facility or community-based residential alternative services from a particular provider. Subject to the availability of an alternative care coordinator, the CONTRACTOR may impose a six (6) month lock-in period with an exception for cause after a member has been granted one (1) change in care coordinators.
- 2.9.6.11.9 In order to ensure quality and continuity of care, the CONTRACTOR shall make efforts to minimize the number of changes in care coordinator assigned to a member. A CONTRACTOR initiated change in care coordinators may be appropriate in the following circumstances:
 - 2.9.6.11.9.1 Care coordinator is no longer employed by the CONTRACTOR;
 - 2.9.6.11.9.2 Care coordinator has a conflict of interest and cannot serve the member;
 - 2.9.6.11.9.3 Care coordinator is on temporary leave from employment; and
 - 2.9.6.11.9.4 Care coordinator caseloads must be adjusted due to the size or intensity of an individual care coordinator's caseload.
- 2.9.6.11.10 The CONTRACTOR shall develop policies and procedures regarding notice to members of care coordinator changes initiated by either the CONTRACTOR or the member, including advance notice of planned care coordinator changes initiated by the CONTRACTOR.
- 2.9.6.11.11 The CONTRACTOR shall ensure continuity of care when care coordinator changes are made whether initiated by the member or by the CONTRACTOR. The CONTRACTOR shall demonstrate use of best practices by encouraging newly assigned care coordinators to attend a face-to-face transition visit with the member and the out-going care coordinator when possible.
- 2.9.6.11.12 The CONTRACTOR shall provide initial training to newly hired care coordinators and ongoing training at least annually to care coordinators. Unless and until directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, training shall focus on the requirements applicable to CHOICES Group 1. When directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the CONTRACTOR shall, as directed by TENNCARE, train care coordinators on requirements applicable to CHOICES Group 2 and/or 3. Initial training topics shall include at a minimum:
 - 2.9.6.11.12.1 The CHOICES program including a description of the CHOICES groups; eligibility for CHOICES enrollment; enrollment in CHOICES; enrollment targets for CHOICES Groups 2 and 3, including reserve capacity and administration of waiting lists; and CHOICES benefits, including benefit limits, the individual cost

- neutrality cap for CHOICES Group 2, the expenditure cap for CHOICES Group 3, and the limited benefit package for members enrolled on the basis of Immediate Eligibility for CHOICES Group 2;
- 2.9.6.11.12.2 Facilitating CHOICES enrollment for current members;
 - 2.9.6.11.12.3 Level of care and needs assessment and reassessment, development of a plan of care, and updating the plan of care including training on the tools and protocols;
 - 2.9.6.11.12.4 Development and implementation of back-up plans (for members in CHOICES Group 2 or 3);
 - 2.9.6.11.12.5 Consumer direction of HCBS (for members in CHOICES Group 2 or 3);
 - 2.9.6.11.12.6 Self-direction of health care tasks (for members in CHOICES Group 2 or 3);
 - 2.9.6.11.12.7 Coordination of care for duals;
 - 2.9.6.11.12.8 Electronic visit verification (for members in CHOICES Group 2 or 3);
 - 2.9.6.11.12.9 Conducting a home visit and use of the monitoring checklist;
 - 2.9.6.11.12.10 How to immediately identify and address service gaps (for members in CHOICES Group 2 or 3);
 - 2.9.6.11.12.11 Management of critical transitions (including hospital discharge planning);
 - 2.9.6.11.12.12 Nursing facility diversion;
 - 2.9.6.11.12.13 Nursing facility to community transitions, including training on tools and protocols;
 - 2.9.6.11.12.14 For members in CHOICES Groups 1 and 2, as applicable, members' responsibility regarding patient liability, including the consequences of not paying patient liability;
 - 2.9.6.11.12.15 Alzheimer's, dementia and cognitive impairments;
 - 2.9.6.11.12.16 Traumatic brain injury;
 - 2.9.6.11.12.17 Physical disabilities;
 - 2.9.6.11.12.18 Disease management;
 - 2.9.6.11.12.19 Behavioral health;
 - 2.9.6.11.12.20 Evaluation and management of risk;
 - 2.9.6.11.12.21 Identifying and reporting abuse/neglect (see Section 2.24.4);
 - 2.9.6.11.12.22 Fraud and abuse, including reporting fraud and abuse;

- 2.9.6.11.12.23 Advance directives and end of life care;
 - 2.9.6.11.12.24 HIPAA;
 - 2.9.6.11.12.25 Cultural competency;
 - 2.9.6.11.12.26 Disaster planning; and
 - 2.9.6.11.12.27 Available community resources for non-covered services.
- 2.9.6.11.13 The CONTRACTOR shall establish roles and job responsibilities for care coordinators. The job responsibilities shall include a description of activities and required timeframes for completion. These activities shall include the requirements specified in this Section 2.9.6.
- 2.9.6.12 Care Coordination Monitoring
- 2.9.6.12.1 The CONTRACTOR shall develop a comprehensive program for monitoring, on an ongoing basis, the effectiveness of its care coordination processes. The CONTRACTOR shall immediately remediate all individual findings identified through its monitoring process, and shall also track and trend such findings and remediations to identify systemic issues of poor performance and/or non-compliance, implement strategies to improve care coordination processes and resolve areas of non-compliance, and shall measure the success of such strategies in addressing identified issues. At a minimum, the CONTRACTOR shall ensure that:
- 2.9.6.12.1.1 Care coordination tools and protocols are consistently and objectively applied and outcomes are continuously measured to determine effectiveness and appropriateness of processes;
 - 2.9.6.12.1.2 Level of care assessments and reassessments occur on schedule and are submitted to TENNCARE in accordance with requirements in Section 2.9.6.9.3.1.1;
 - 2.9.6.12.1.3 Needs assessments and reassessment, as applicable, occur on schedule and in compliance with this Agreement;
 - 2.9.6.12.1.4 Plans of care for CHOICES Groups 2 and 3 are developed and updated on schedule and in compliance with this Agreement;
 - 2.9.6.12.1.5 Plans of care for CHOICES Groups 2 and 3 reflect needs identified in the needs assessment and reassessment process;
 - 2.9.6.12.1.6 Plans of care for CHOICES Groups 2 and 3 are appropriate and adequate to address member needs;
 - 2.9.6.12.1.7 Services are delivered as described in the plan of care and authorized by the CONTRACTOR;
 - 2.9.6.12.1.8 Services are appropriate to address the member's needs;

- 2.9.6.12.1.9 Services are delivered in a timely manner;
- 2.9.6.12.1.10 Service utilization is appropriate;
- 2.9.6.12.1.11 Service gaps are identified and addressed in a timely manner;
- 2.9.6.12.1.12 Minimum care coordinator contacts are conducted;
- 2.9.6.12.1.13 Care coordinator-to-member ratios are appropriate;
- 2.9.6.12.1.14 The cost neutrality cap for members in CHOICES Group 2 and the expenditure cap for members in CHOICES Group 3 are monitored and appropriate action is taken if a member is nearing or exceeds his/her cost neutrality or expenditure cap; and
- 2.9.6.12.1.15 That benefit limits are monitored and that appropriate action is taken if a member is nearing or exceeds a benefit limit.
- 2.9.6.12.2 The CONTRACTOR shall provide to TENNCARE the reports required by Section 2.30.
- 2.9.6.12.3 The CONTRACTOR shall purchase and implement an electronic visit verification system to monitor member receipt and utilization of HCBS (for members enrolled in CHOICES Group 2 or Group 3) including at a minimum, personal care, attendant care, homemaker services and home-delivered meals. The CONTRACTOR shall select its own electronic visit verification vendor and shall ensure, in the development of such system, the following minimal functionality:
 - 2.9.6.12.3.1 The ability to log the arrival and departure of an individual provider staff person or worker;
 - 2.9.6.12.3.2 The ability to verify in accordance with business rules that services are being delivered in the correct location (e.g., the member's home);
 - 2.9.6.12.3.3 The ability to verify the identity of the individual provider staff person or worker providing the service to the member;
 - 2.9.6.12.3.4 The ability to match services provided to a member with services authorized in the plan of care;
 - 2.9.6.12.3.5 The ability to ensure that the provider/worker delivering the service is authorized to deliver such services;
 - 2.9.6.12.3.6 The ability to establish a schedule of services for each member which identifies the time at which each service is needed, and the amount, frequency, duration and scope of each service, and to ensure adherence to the established schedule;
 - 2.9.6.12.3.7 The ability to provide immediate (i.e., "real time") notification to care coordinators if a provider or worker does not arrive as scheduled or otherwise deviates from the authorized schedule so that service gaps and the reason the

- service was not provided as scheduled, are immediately identified and addressed, including through the implementation of back-up plans, as appropriate;
- 2.9.6.12.3.8 The ability for a provider of home-delivered meals to log in and enter the meals that have been delivered during the day, including the member's name, time delivered and the reason a meal was not delivered (when applicable);
- 2.9.6.12.3.9 The ability for a provider, e.g., adult day care provider, to log in and enter attendance for the day; and
- 2.9.6.12.3.10 The CONTRACTOR shall ensure that the EVV system creates and makes available to providers and to the FEA on at least a daily basis an electronic claims submission file in the 837 format, including exceptions which have been resolved, which may be submitted to the CONTRACTOR for claims processing at the appropriate frequency.
- 2.9.6.12.4 The CONTRACTOR shall not require that provider staff delivering home-delivered meals log in at arrival and departure. Instead, the provider may opt to log in on a daily basis after meals have been delivered and enter information on all the meals that were delivered that day (see Section 2.9.6.12.3.8 above).
- 2.9.6.12.5 The CONTRACTOR shall monitor and use information from the electronic visit verification system to verify that services to members in CHOICES Group 2 or Group 3 are provided as specified in the plan of care, and in accordance with the established schedule, including the amount, frequency, duration, and scope of each service, and that services are provided by the authorized provider/worker; and to identify and immediately address service gaps, including late and missed visits. The CONTRACTOR shall monitor services anytime a member is receiving services, including after the CONTRACTOR's regular business hours.
- 2.9.6.12.6 The CONTRACTOR shall develop and maintain an electronic case management system that includes the functionality to ensure compliance with all requirements specified in the Section 1115 TennCare Demonstration Waiver, federal and state laws and regulations, this Agreement, and TennCare policies and protocols, including but not limited to the following:
- 2.9.6.12.6.1 The ability to capture and track key dates and timeframes specified in this Agreement, e.g., as applicable, date of referral for potential CHOICES enrollment, date the level of care assessment and plan of care were submitted to TENNCARE, date of CHOICES enrollment, date of development of the plan of care, date of authorization of the plan of care, date of initial service delivery for each service in the plan of care, date of each level of care and needs reassessment, date of each update to the plan of care, and dates regarding transition from a nursing facility to the community;
- 2.9.6.12.6.2 The ability to capture and track compliance with minimum care coordination contacts as specified in Section 2.9.6.9.4 of this Agreement;
- 2.9.6.12.6.3 The ability to notify the care coordinator about key dates, e.g., TennCare eligibility end date, date for annual level of care reassessment, date of needs reassessment, and date for update to the plan of care;

- 2.9.6.12.6.4 The ability to capture and track eligibility/enrollment information, level of care assessments and reassessments, and needs assessments and reassessments;
- 2.9.6.12.6.5 The ability to capture and monitor the plan of care;
- 2.9.6.12.6.6 The ability to track requested and approved service authorizations, including covered long-term care services and any services provided as a cost-effective alternative to other covered services;
- 2.9.6.12.6.7 The ability to document all referrals received by the care coordinator on behalf of the member for covered long-term care services; home health and private duty nursing services; other physical or behavioral health services needed to help the member maintain or improve his or her physical or behavioral health status or functional abilities and maximize independence; and other social support services and assistance needed in order to ensure the member's health, safety and welfare, and as applicable, to delay or prevent the need for more expensive institutional placement, including notes regarding how such referral was handled by the care coordinator;
- 2.9.6.12.6.8 The ability to establish a schedule of services for each member which identifies the time at which each service is needed and the amount, frequency, duration and scope of each service;
- 2.9.6.12.6.9 The ability to provide, via electronic interface with the electronic visit verification system, service authorizations on behalf of a member in CHOICES Group 2 or 3, including the schedule at which each service is needed;
- 2.9.6.12.6.10 The ability to provide, via electronic interface with the FEA, referrals and service authorizations for members in CHOICES Group 2 or 3 who are participating in consumer direction of HCBS;
- 2.9.6.12.6.11 The ability to track service delivery against authorized services and providers;
- 2.9.6.12.6.12 The ability to track actions taken by the care coordinator to immediately address service gaps for members in CHOICES Group 2 or 3; and
- 2.9.6.12.6.13 The ability to document case notes relevant to the provision of care coordination.

2.9.7 Consumer Direction of HCBS

2.9.7.1 General

- 2.9.7.1.1 Requirements regarding consumer direction of HCBS will not apply to the CONTRACTOR unless and until the CONTRACTOR is directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3. If directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the CONTRACTOR shall offer consumer direction of HCBS to all CHOICES Group 2 and 3 members who are determined by a care coordinator, through the needs assessment/reassessment process, to need attendant care, personal care, homemaker, in-home respite, companion care services and/or any

other service specified in TennCare rules and regulations as available for consumer direction. (Companion care is only available for persons electing consumer direction of HCBS.) A service that is not specified in TennCare rules and regulations as available for consumer direction shall not be consumer directed. Consumer direction in CHOICES affords members the opportunity to have choice and control over how eligible HCBS are provided, who provides the services and how much workers are paid for providing care, up to a specified maximum amount established by TENNCARE (see Section 2.9.7.6.11). Member participation in consumer direction of HCBS is voluntary. Members may elect to participate in or withdraw from consumer direction of HCBS at any time, service by service, without affecting their enrollment in CHOICES. To the extent possible, the member shall provide his/her care coordinator ten (10) days advance notice regarding his/her intent to no longer direct one or more eligible HCBS or to withdraw from participation in consumer direction of HCBS entirely. The CONTRACTOR shall respond to the member's request in keeping with the timeframes and processes set forth in this Section, in order to facilitate a seamless transition to appropriate service delivery. TENNCARE may establish reasonable limitations on the frequency with which members may opt into and out of consumer direction of HCBS.

- 2.9.7.1.2 Consumer direction is a process by which eligible HCBS are delivered; it is not a service. If a member chooses not to direct his/her care, he/she shall receive authorized HCBS through contract providers. While the denial of a member's request to participate in consumer direction or the termination of a member's participation in consumer direction gives rise to due process including the right to fair hearing, such appeals shall be processed by the TennCare Division of Long Term Care rather than the TennCare Solutions Units, which manages medical appeals pertaining to TennCare benefits (i.e., services).
- 2.9.7.1.3 Members who participate in consumer direction of HCBS choose either to serve as the employer of record of their workers or to designate a representative (see definition below in Section 2.9.7.2.1) to serve as the employer of record on his/her behalf. As the employer of record the member or his/her representative is responsible for the following:
 - 2.9.7.1.3.1 Recruiting, hiring and firing workers;
 - 2.9.7.1.3.2 Determining workers' duties and developing job descriptions;
 - 2.9.7.1.3.3 Scheduling workers;
 - 2.9.7.1.3.4 Supervising workers;
 - 2.9.7.1.3.5 Evaluating worker performance and addressing any identified deficiencies or concerns;
 - 2.9.7.1.3.6 Setting wages up to a specified maximum amount established by TENNCARE;
 - 2.9.7.1.3.7 Training workers to provide personalized care based on the member's needs and preferences;

- 2.9.7.1.3.8 Ensuring that workers deliver only those services authorized, and reviewing and approving hours worked by consumer-directed workers;
 - 2.9.7.1.3.9 Reviewing and ensuring proper documentation for services provided; and
 - 2.9.7.1.3.10 Developing and implementing as needed a back-up plan to address instances when a scheduled worker is not available or fails to show up as scheduled.
- 2.9.7.2 Representative
- 2.9.7.2.1 A member may designate, or have appointed by a guardian, a representative to assume the consumer direction responsibilities on his/her behalf. A representative shall meet, at minimum the following requirements: be at least 18 years of age, have a personal relationship with the member and understand his/her support needs; knows the member's daily schedule and routine, medical and functional status, medication regimen, likes and dislikes, and strengths and weaknesses; and be physically present in the member's residence on a regular basis or at least at a frequency necessary to supervise and evaluate each worker.
 - 2.9.7.2.2 In order to participate in consumer direction of HCBS with the assistance of a representative, one of the following must apply: (1) the member must have the ability to designate a person to serve as his/her representative or (2) the member has a legally appointed representative who may serve as the member's representative.
 - 2.9.7.2.3 The care coordinator shall, based on a self-assessment completed by the member, determine if the member requires assistance in carrying out the responsibilities required for consumer direction and therefore requires a representative. The member's care coordinator/care coordination team shall verify that a representative meets the qualifications as described in Section 2.9.7.2.1 above.
 - 2.9.7.2.4 A member's representative shall not receive payment for serving in this capacity and shall not serve as the member's worker for any consumer directed service. The CONTRACTOR shall use a representative agreement developed by TENNCARE to document a member's choice of a representative for consumer direction of HCBS and the representative's contact information, and to confirm the individual's agreement to serve as the representative and to accept the responsibilities and perform the associated duties defined therein. The CONTRACTOR shall notify the FEA within three (3) business days when it becomes aware of any changes to a representative's contact information.
 - 2.9.7.2.5 The representative agreement shall be signed by the member (or person authorized to sign on member's behalf) and the representative in the presence of the care coordinator. The care coordinator shall include the representative agreement in the member's file and provide copies to the member and/or the member's representative and the FEA.
 - 2.9.7.2.6 A member may change his/her representative at any time. The member shall immediately notify his/her care coordinator and his/her supports broker when he/she intends to change representatives. The care coordinator shall verify that the new representative meets the qualifications as described above. A new representative agreement shall be completed and signed, in the presence of a care coordinator, prior

to the new representative assuming their respective responsibilities. The care coordinator shall immediately notify the FEA in writing when a member changes his/her representative and provide a copy of the representative agreement. The CONTRACTOR shall facilitate a seamless transition to the new representative, and ensure that there are no interruptions or gaps in services. As part of the needs assessment and plan of care process, the care coordinator shall educate the member about the importance of notifying the care coordinator prior to changing a representative.

2.9.7.2.7 The FEA shall ensure that the new representative signs all service agreements (see Section 2.9.7.6.6).

2.9.7.3 Fiscal Employer Agent (FEA)

2.9.7.3.1 The CONTRACTOR shall enter into a contract with the FEA specified by TENNCARE to provide assistance to members choosing consumer direction.

2.9.7.3.2 The FEA shall fulfill, at a minimum, the following financial administration and supports brokerage functions, as specified in the CONTRACTOR's contract with the FEA and the FEA's contract with TENNCARE, for all CHOICES members electing consumer direction of HCBS:

2.9.7.3.2.1 Assign a supports broker to each CHOICES member electing to participate in consumer direction of HCBS;

2.9.7.3.2.2 Assist in identifying and addressing in the risk assessment and plan of care processes any additional risk associated with the member participating in consumer direction;

2.9.7.3.2.3 Provide initial and ongoing training to members and their representatives (as applicable) on consumer direction and other relevant issues (see Section 2.9.7.7 of this Agreement);

2.9.7.3.2.4 Verify worker qualifications, including, as specified by TENNCARE, conduct background checks on workers, enroll workers into Medicaid, assign provider Medicaid ID numbers, and hold Medicaid provider agreements (see Section 2.9.7.6.1 of this Agreement);

2.9.7.3.2.5 Provide initial and ongoing training to workers on consumer direction and other relevant issues (see Section 2.9.7.7 of this Agreement);

2.9.7.3.2.6 Assist the member and/or representative in developing and updating service agreements (see Section 2.9.7.6.6);

2.9.7.3.2.7 Receive, review and process electronically captured visit information;

2.9.7.3.2.8 Resolve discrepancies regarding electronically captured visit information;

2.9.7.3.2.9 Obtain documentation from the member and/or representative to ensure that services were provided prior to payment of workers;

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- 2.9.7.3.2.10 Withhold, file and pay applicable: federal, state and local income taxes; employment and unemployment taxes; and worker's compensation;
- 2.9.7.3.2.11 Pay workers for authorized services rendered within authorized timeframes;
- 2.9.7.3.2.12 Facilitate resolution of any disputes regarding payment to workers for services rendered;
- 2.9.7.3.2.13 Monitor quality of services provided by workers; and
- 2.9.7.3.2.14 Report to the CONTRACTOR on worker and/or staff identification of, response to, participation in and/or investigation of critical incidents (see Section 2.15.7).
- 2.9.7.3.3 The FEA shall also fulfill, at a minimum, the following financial administration and supports brokerage functions for CHOICES members electing consumer direction of HCBS on an as needed basis:
 - 2.9.7.3.3.1 Assist the member and/or representative in developing job descriptions;
 - 2.9.7.3.3.2 Assist the member and/or representative in locating and recruiting workers;
 - 2.9.7.3.3.3 Assist the member and/or representative in interviewing workers (developing questions, evaluating responses);
 - 2.9.7.3.3.4 Assist the member and/or representative in scheduling workers;
 - 2.9.7.3.3.5 Assist the member and/or representative in managing and monitoring payments to workers; and
 - 2.9.7.3.3.6 Assist the member and/or representative in monitoring and evaluating the performance of workers.
- 2.9.7.3.4 The CONTRACTOR's care coordination functions shall not duplicate the supports brokerage functions performed by the FEA or its subcontractor. A member's care coordinator shall work with and coordinate with a member's supports broker in implementing and monitoring consumer direction.
- 2.9.7.3.5 The CONTRACTOR's contract with the FEA shall include the provisions specified by TENNCARE in the model CONTRACTOR-FEA contract.
- 2.9.7.3.6 The CONTRACTOR in collaboration with the FEA shall establish a process that allows for the efficient exchange of all relevant member information regarding members electing to participate in consumer direction between the CONTRACTOR and the FEA.
- 2.9.7.3.7 The CONTRACTOR and FEA shall develop a protocol for interfaces and transfers of customer service inquiries per the requirements of Section 2.18 of this Agreement.
- 2.9.7.3.8 The CONTRACTOR shall provide to the FEA copies of all relevant initial and updated member documents, including at a minimum, plans of care,

representative agreements and risk agreements. The CONTRACTOR shall provide to the FEA all relevant documentation prior to service delivery.

- 2.9.7.3.9 The CONTRACTOR shall require that the EVV system: (1) provide functionality and access to the FEA for purposes of scheduling workers who will deliver services in accordance with the schedule determined by the CONTRACTOR and for monitoring service delivery; and (2) facilitate access by the FEA to electronically captured visit information in order to process exceptions, to process payroll for workers, and for purposes of claims submission to the CONTRACTOR once exceptions have been resolved.
- 2.9.7.3.10 The FEA shall screen monthly to determine if workers have been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded. If a worker has been excluded, the FEA shall notify the member regarding the worker's status and work with the member to find a replacement worker. The FEA shall notify the CONTRACTOR regarding the worker status. The CONTRACTOR shall work with the member to obtain a replacement contract provider until a replacement worker can be found and all worker requirements are fulfilled and verified.
- 2.9.7.3.11 *FEA Training*
- 2.9.7.3.11.1 The CONTRACTOR shall provide education and training to the FEA and its staff and subcontracted supports brokers (as applicable) regarding key requirements of this Agreement and the contract between the CONTRACTOR and the FEA.
- 2.9.7.3.11.2 The CONTRACTOR shall provide to the FEA, in electronic format (including but not limited to CD or access via a web link), a member handbook and updates thereafter annually or any time material changes are made.
- 2.9.7.3.11.3 The CONTRACTOR shall conduct initial education and training to the FEA and its staff at least thirty (30) days prior to enrolling members in CHOICES Group 2 and/or 3 (if and when directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3). This education and training shall include, but not be limited to, the following:
- 2.9.7.3.11.3.1 The role and responsibilities of the care coordinator, including as it relates to members electing to participate in consumer direction;
- 2.9.7.3.11.3.2 CHOICES needs assessment and care planning development, implementation, and monitoring processes, including the development and activation of a back-up plan for members participating in consumer direction;
- 2.9.7.3.11.3.3 The FEA's responsibilities for communicating with the CONTRACTOR, members, representatives and workers and TENNCARE, and the process by which to do this;
- 2.9.7.3.11.3.4 Customer service requirements;

- 2.9.7.3.11.3.5 Requirements and processes regarding referral to the FEA;
- 2.9.7.3.11.3.6 Requirements and processes, including timeframes for authorization of consumer directed HCBS;
- 2.9.7.3.11.3.7 Requirements and processes, including timeframes, for claims submission and payment and coding requirements;
- 2.9.7.3.11.3.8 Systems requirements and information exchange requirements;
- 2.9.7.3.11.3.9 Requirements regarding the EVV system;
- 2.9.7.3.11.3.10 Requirements and role and responsibility regarding abuse and neglect plan protocols, and critical incident reporting and management;
- 2.9.7.3.11.3.11 The FEA's role and responsibility in implementing the CONTRACTOR's fraud and abuse plan;
- 2.9.7.3.11.3.12 CHOICES program quality requirements; and
- 2.9.7.3.11.3.13 The CONTRACTOR's member complaint and appeal processes.
- 2.9.7.3.11.4 The CONTRACTOR shall provide ongoing FEA education, training and technical assistance as deemed necessary by the CONTRACTOR or TENNCARE in order to ensure compliance with this Agreement and the contract between the CONTRACTOR and the FEA.
- 2.9.7.3.11.5 The CONTRACTOR shall require the Electronic Visit Verification (EVV) vendor to provide training to the FEA and its supports brokers regarding the EVV system, and a training curriculum that shall be utilized by the FEA in training consumer-directed workers.
- 2.9.7.3.11.6 The FEA shall provide training to the CONTRACTOR's care coordinators regarding consumer direction of HCBS and the role and responsibilities of the FEA (including financial administration and supports brokerage functions)
- 2.9.7.4 Needs Assessment/Plan of Care Process
 - 2.9.7.4.1 A CHOICES member may choose to direct needed eligible HCBS at anytime: during CHOICES intake, through the needs assessment/reassessment and plan of care and plan of care update processes; and outside of these processes. The care coordinator shall assess the member's needs for eligible HCBS per requirements in Sections 2.9.6.2.4, 2.9.6.3 and 2.9.6.5, as applicable. The care coordinator shall use the plan of care process (including updates) to identify the eligible services that the member will direct and to facilitate the member's enrollment in consumer direction of HCBS.
 - 2.9.7.4.2 The CONTRACTOR shall obtain from the member a signed statement regarding the member's decision to participate in consumer direction of HCBS.
 - 2.9.7.4.2.1 The care coordinator shall assist the member in identifying which of the needed eligible HCBS shall be consumer directed, provided by contract providers or a

combination of both, in which case, there must be a set schedule which clearly defines when contract providers will be utilized. The CONTRACTOR shall not be expected or required to maintain contract providers “on standby” to serve in a back-up capacity for services a member has elected to receive through consumer direction.

- 2.9.7.4.3 If the member intends to direct one or more needed eligible HCBS, throughout the period of time that consumer direction is being initiated, the CONTRACTOR shall arrange for the provision of needed HCBS through contract providers in accordance with 2.9.6. The care coordinator shall obtain from the member his/her choice of contract providers who will provide HCBS until such time as workers are secured and ready to begin delivering care through consumer direction.
- 2.9.7.4.3.1 If a member has been assessed to need companion care services, the CONTRACTOR shall identify non-residential services that will offer interim support to address the member’s needs and assist the member in obtaining contract providers for these services.
- 2.9.7.4.4 The CONTRACTOR shall be responsible for providing all needed eligible HCBS using contract providers, including a back-up plan for such services, until all necessary requirements have been fulfilled in order to implement consumer direction of HCBS, including but not limited to: the FEA verifies that workers for these services meet all necessary requirements (see Section 2.9.7.6.1 of this Agreement); service agreements are completed and signed; and authorizations for consumer directed services are in place. The CONTRACTOR, in conjunction with the FEA, shall facilitate a seamless transition between contract providers and workers and ensure that there are no interruptions or gaps in services.
- 2.9.7.4.5 The care coordinator shall determine if the member will appoint a representative to assume the consumer direction functions on his/her behalf. If the member does not intend to appoint a representative, the care coordinator shall determine the extent to which a member requires assistance to participate in consumer direction of HCBS, based upon the results of the member’s responses to the self-assessment instrument developed by TENNCARE. The self-assessment instrument shall be completed by the member with assistance from the member’s care coordinator as appropriate. The care coordinator shall file the completed self-assessment in the member’s file.
- 2.9.7.4.5.1 If, based on the results of the self-assessment the care coordinator determines that a member requires assistance to direct his/her services, the care coordinator shall inform the member that he/she will need to designate a representative to assume the consumer direction functions on his/her behalf.
- 2.9.7.4.5.2 The CONTRACTOR shall forward to TENNCARE for disposition, pursuant to TennCare policy, any cases in which the CONTRACTOR plans to deny participation in consumer direction because a care coordinator has determined that the health, safety and welfare of the member would be in jeopardy if the member participates in consumer direction without a representative but the member does not want to appoint a representative to assist in directing his/her services. The CONTRACTOR shall abide by TENNCARE’s decision.

- 2.9.7.4.6 The member's care coordinator/care coordination team shall ensure that the person identified to serve as the representative meets all qualifications (see Section 2.9.7.2.1 of this Agreement) and that a representative agreement is completed and signed by the member and the person prior to forwarding a referral to the FEA (see Section 2.9.7.4.7 below).
- 2.9.7.4.7 Within two (2) business days of signing the representative agreement or completion of the self-assessment instrument if the member has not designated a representative and the care coordinator determines that the member does not require a representative to assist the member in directing his/her care, the CONTRACTOR shall forward to the FEA a referral initiating the member's participation in consumer direction of HCBS. The referral shall include at a minimum: the date of the referral; the member's name, address, telephone number, and social security number (SSN); the name of the representative and telephone number (if applicable); member's MCO ID number; member's CHOICES enrollment date; eligible selected HCBS, including amount, frequency and duration of each by type; and care coordinator's name and contact information. The CONTRACTOR shall also forward to the FEA a copy of the written confirmation of the member's decision to participate in consumer direction of HCBS. Referrals shall be submitted electronically on a daily basis using the agreed upon data interface (either a standard electronic file transfer or the FEA's web portal technology or both) and process. Referrals shall be submitted on a member-by-member basis.
- 2.9.7.4.8 Within two (2) business days of receipt of the referral, the FEA shall assign a supports broker to the member, notify the care coordinator of the assignment and provide the name and contact information of the supports broker.
- 2.9.7.4.9 Within five (5) days of receipt of the referral, the FEA shall contact the member to inform the member of his/her assigned supports broker, provide contact information for the supports broker, and to begin the process of initiating consumer direction of HCBS.
- 2.9.7.4.10 *Back-up Plan for Consumer Direction and Updated Risk Assessment/Risk Agreement*
- 2.9.7.4.10.1 The FEA shall assist the member/representative as needed in developing a back-up plan for consumer direction that adequately identifies how the member/representative will address situations when a scheduled worker is not available or fails to show up as scheduled. The member/representative (as applicable) shall have primary responsibility for the development and implementation of the back-up plan for consumer directed services.
- 2.9.7.4.10.2 The member/representative (as applicable) may not elect, as part of the back-up plan, to go without services.
- 2.9.7.4.10.3 The back-up plan for consumer direction shall include the names and telephone numbers of contacts (workers, agency staff, organizations, supports) for alternate care, the order in which each shall be notified and the services to be provided by contacts. Back-up contacts may include paid and unpaid supports; however, it is the responsibility of the member electing consumer direction and/or his/her representative to secure paid (as well as unpaid) back-up contacts who are willing and available to serve in this capacity. The CONTRACTOR shall not be

expected or required to maintain contract providers “on standby” to serve in a back-up capacity for services a member has elected to receive through consumer direction.

- 2.9.7.4.10.4 All persons and/or organizations noted in the back-up plan for consumer direction shall be contacted by the member/representative to determine their willingness and availability to serve as back-up contacts. The FEA shall confirm with these persons and/or organizations to confirm their willingness and availability to provide care when needed, document confirmation in the member’s file and forward a copy of the documentation to the CONTRACTOR.
- 2.9.7.4.10.5 The member’s care coordinator shall integrate the member’s back-up plan for consumer-directed workers (including any updates thereto) into the member’s back-up plan for services provided by contract providers, as applicable, and the member’s plan of care. The care coordinator shall review the back-up plan developed by the member or his/her representative (as applicable) for consumer direction to determine its adequacy to address the member’s needs, and shall monitor for late and missed visits and to ensure that the back-up plan was implemented timely and that the member’s needs are being met.
- 2.9.7.4.10.6 The FEA shall assist the member or his/her representative (as applicable) in implementing the back-up plan for consumer direction as needed, monitor to ensure that the back-up plan is implemented and effectively working to address the member’s needs, and notify the care coordinator immediately regarding any concerns with the back-up plan or the member’s care.
- 2.9.7.4.10.7 The FEA shall assist the member or his/her representative (as applicable) in reviewing and updating the back-up plan for consumer direction at least annually and as frequently as necessary, which shall include any time there are changes in the type, amount, duration, scope of eligible HCBS or the schedule at which such services are needed, changes in workers (when such workers also serve as a back-up to other workers) and changes in the availability of paid or unpaid back-up workers to deliver needed care. As part of the annual review of the back-up plan, the member or his/her representative and the FEA shall confirm that each person specified in the back-up plan continues to be willing and available to serve as back-up workers to deliver needed care and to perform the tasks and functions needed by the member. Any updates to the back-up plan for consumer direction shall be provided to the member’s care coordinator.
- 2.9.7.4.10.8 The FEA and the CONTRACTOR shall each file a copy of the back-up plan for consumer direction in the member’s file.
- 2.9.7.4.10.9 The member’s care coordinator shall reassess the adequacy of the member’s back-up plan for consumer direction on at least an annual basis which shall include any time there are changes in the type, amount, duration, scope of eligible HCBS or the schedule at which such services are needed, changes in consumer-directed workers (when such workers also serve as a back-up to other workers) or changes in the availability of paid or unpaid back-up workers to deliver needed care.

- 2.9.7.4.10.10 The CONTRACTOR shall develop and/or update, as applicable, a risk agreement which takes into account the member's decision to participate in consumer direction, and which identifies any additional risks associated with the member's decision to direct his/her services, the potential consequences of such risk, as well as measures to mitigate these risks. The member/representative shall participate in the process. The member's representative (if applicable) shall participate in the risk assessment process. Once a referral has been made to the FEA for consumer direction, the member's supports broker should be involved in risk assessment and risk planning activities whenever possible. The new or updated risk agreement, as applicable, shall be signed by the care coordinator and the member or his/her representative (as applicable). The CONTRACTOR, member/representative and FEA shall receive a copy of the risk agreement. The CONTRACTOR and the FEA shall each file a copy of the risk agreement in the member's file.
- 2.9.7.4.10.11 The FEA shall notify the member's care coordinator immediately when there are changes in the member's needs and/or circumstances which warrant a reassessment of needs and/or risk, or changes to the plan of care or risk agreement.
- 2.9.7.4.10.12 The FEA shall assist the CONTRACTOR in identifying and addressing in the risk assessment and plan of care processes any additional risk associated with the member participating in consumer direction.
- 2.9.7.4.10.13 On an ongoing basis, the CONTRACTOR shall ensure that needs reassessments and updates to the plan of care occur per requirements specified in Sections 2.9.6.9 of this Agreement. The care coordinator shall ensure that the member's supports broker is invited to participate in these meetings.
- 2.9.7.5 Authorizations for Consumer Directed Services and Service Initiation
- 2.9.7.5.1 Consumer direction of HCBS shall not be initiated until all requirements are fulfilled including but not limited to the following: (1) the FEA verifies that the member's employer and related documentation is in order; (2) the FEA verifies that workers meet all qualifications, including participation in required training; (3) there is a signed service agreement specific to each individual worker (see Section 2.9.7.6.6 of this Agreement); and (4) the CONTRACTOR issues to the FEA an authorization for consumer directed services (see 2.9.7.5.6 below) for each service.
- 2.9.7.5.2 The FEA shall work with the member to determine the appropriate level of assistance necessary to recruit, interview and hire workers and provide the assistance.
- 2.9.7.5.3 Once potential workers are identified, the FEA shall verify that a potential worker meets all applicable qualifications (see Section 2.9.7.6.1 of this Agreement).
- 2.9.7.5.4 The FEA shall ensure that a service agreement is signed between the member or member's representative and his/her worker within five (5) business days following the FEA's verification that a worker meets all qualifications.
- 2.9.7.5.5 The FEA shall periodically update the member's care coordinator of the status of completing required functions necessary to initiate consumer direction, including

obtaining completed paperwork from the member/representative and obtaining workers for each identified consumer directed service and any anticipated timeframes by which qualified workers shall be secured and consumer directed services may begin.

- 2.9.7.5.6 The provision of consumer directed services shall begin as soon as possible but no longer than sixty (60) days from the date of the CONTRACTOR's referral to the FEA, except due to circumstances beyond the control of the FEA. Prior to beginning the provision of consumer directed services, the FEA shall notify the CONTRACTOR that all requirements have been fulfilled, including verification of all worker qualifications, criminal background checks, signed service agreements, and that the member is ready to begin consumer direction of HCBS. Within two (2) business days of receipt of the notification from the FEA, the CONTRACTOR shall forward to the FEA an authorization for consumer directed services. Each authorization for consumer directed services shall include authorized service; authorized units of service, including amount, frequency and duration and the schedule at which services are needed; start and end dates; and service code(s). Authorized units of service in a service authorization should reflect the units of measure specified by TENNCARE for the benefit (e.g. visits, hours, days). The CONTRACTOR shall submit authorizations electronically on at least a daily basis using the agreed upon data interface (which may include a standard electronic file transfer, the FEA's web portal technology, the EVV system, or any combination thereof).
- 2.9.7.5.7 If initiation of consumer directed services does not begin within sixty (60) days from the date of the CONTRACTOR's referral to the FEA, the FEA shall contact the CONTRACTOR regarding the cause of the delay and provide appropriate documentation to demonstrate efforts to meet the timeframe. The CONTRACTOR shall determine the appropriate next steps, including but not limited to whether additional time is needed or if the member is still interested in participating in consumer direction of HCBS.
- 2.9.7.5.8 Upon the scheduled start date of consumer directed services, the member's care coordinator/care coordination team shall begin monitoring to ensure that services have been initiated and continue to be provided as authorized. This shall include ongoing monitoring via electronic visit verification to ensure that services are provided in accordance with the member's plan of care, including the amount, frequency, duration and scope of each service, in accordance with the member's service schedule. Upon the identification of any gaps in care, the member's care coordinator/care coordination team shall contact the FEA who shall assist the member or his/her representative as needed in implementing the member's back-up plan for consumer direction.
- 2.9.7.5.9 Within five (5) business days of the scheduled start date of consumer directed services as specified in the authorization of consumer directed services, a member of the care coordinator team shall contact the member or his/her representative to confirm that services are being provided and that the member's needs are being met.
- 2.9.7.5.10 On an ongoing basis, in addition to requirements specified above in 2.9.7.5.3 – 2.9.7.5.9 above:

2.9.7.5.10.1 The CONTRACTOR shall develop and forward to the FEA a new authorization for consumer directed services when the following occur: a change in the number of service units, or the frequency or duration of service delivery, or a change in the schedule at which services are needed; or a change in the services to be provided through consumer direction, including the provision of a new service through consumer direction or termination of a service through consumer direction.

2.9.7.6 Worker Qualifications

2.9.7.6.1 As prescribed in the FEA's contract with TENNCARE, the FEA shall ensure that workers meet all requirements prior to the worker providing services. The FEA shall ensure that workers: meet all TennCare established requirements for providers of comparable, non-consumer directed services; pass a background check which includes criminal background check (including fingerprinting), or, as an alternative, a background check from a licensed private investigation company, verification that the person's name does not appear on the State abuse registry, verification that the person's name does not appear on the state and national sexual offender registries and licensure verification, as applicable; complete all required training, including the training specified in Section 2.9.7.7 of this Agreement; complete all required applications to become a TennCare provider; sign an abbreviated Medicaid agreement; are assigned a Medicaid provider ID number; and sign a service agreement.

2.9.7.6.1.1 A member cannot waive a background check for a potential worker. The following findings shall disqualify a person from serving as a worker:

2.9.7.6.1.1.1 Conviction of an offense involving physical, sexual or emotional abuse, neglect, financial exploitation or misuse of funds, misappropriation of property, theft from any person, violence against any person, or manufacture, sale, possession or distribution of any drug;

2.9.7.6.1.1.2 Entering of a plea of nolo contendere or when a jury verdict of guilty is rendered but adjudication of guilt is withheld with respect to a crime reasonably related to the nature of the position sought or held;

2.9.7.6.1.1.3 Identification on the abuse registry;

2.9.7.6.1.1.4 Identification on the state or national sexual offender registry;

2.9.7.6.1.1.5 Failure to have a required license; and

2.9.7.6.1.1.6 Refusal to cooperate with a background check.

2.9.7.6.1.2 If a worker fails the background check, the FEA shall make the decision regarding exceptions to disqualification in accordance with TennCare policy. In the event a member chooses to hire a worker that has failed a background check but has met all of the conditions for an exception to disqualification, as prescribed by TennCare, and the FEA has granted the exception, the FEA shall notify the member's care coordinator prior to initiation of services provided by

that worker. Exceptions to disqualification may be granted at the member's discretion and only if all of the following conditions are met:

- 2.9.7.6.1.2.1 Offense is a misdemeanor;
- 2.9.7.6.1.2.2 Offense occurred more than five (5) years ago;
- 2.9.7.6.1.2.3 Offense is not related to physical or sexual or emotional abuse of another person;
- 2.9.7.6.1.2.4 Offense does not involve violence against another person or the manufacture, sale, or distribution of drugs; and
- 2.9.7.6.1.2.5 There is only one disqualifying offense.
- 2.9.7.6.2 Workers are not required to be contract providers. The CONTRACTOR shall not require a worker to sign a provider agreement or any other agreement not specified by TENNCARE.
- 2.9.7.6.3 Members shall have the flexibility to hire persons with whom they have a close personal relationship to serve as a worker, such as a neighbor or a friend.
- 2.9.7.6.4 Members may hire family members, excluding spouses, to serve as a worker. A family member shall not be reimbursed for a service that he/she would have otherwise provided without pay. The CONTRACTOR shall use the needs assessment process (see Section 2.9.6.5) to assess the member's available existing supports, including supports provided by family members.
- 2.9.7.6.5 A member may have multiple workers or both a worker and a contract provider for a given service, in which case, there must be a set schedule which clearly defines when contract providers will be utilized. A member may elect to have a worker provide more than one service.
- 2.9.7.6.6 A member shall develop a service agreement with each worker. The service agreement template shall be developed by TENNCARE and shall include, at a minimum: the roles and responsibilities of the worker and the member; the worker's schedule (as developed by the member and/or representative), including hours and days; the scope of each service, i.e., the specific tasks and functions the worker is to perform; the service rate; and the requested start date for services. The service agreement shall serve as the worker's written confirmation of his/her commitment to initiate services on or before the date specified and to provide services in accordance with specified terms (including the tasks and functions to be performed and the schedule at which care is needed). If necessary, the FEA shall assist in this process. Service agreements shall be updated anytime there is a change in any of the terms or conditions specified in the agreement. Service agreements shall be signed by the new representative when there is a change in representatives.
- 2.9.7.6.7 The service agreement shall also stipulate if a worker will provide one or more self-directed health care tasks, the specific task(s) to be performed, and the frequency of each self-directed health care task (see Section 2.7 3).

- 2.9.7.6.8 The FEA shall ensure that a service agreement is in place for each worker prior to the worker providing services.
- 2.9.7.6.9 A copy of each service agreement shall be provided to the member and/or representative. The FEA shall give a copy of the service agreement to the worker and shall maintain a copy for its files.
- 2.9.7.6.10 A member may terminate a worker at any time if he/she feels that the worker is not adhering to the terms of the service agreement and/or is not providing quality services. If the FEA or care coordinator has concerns that a worker is unable to deliver appropriate care as prescribed in the service agreement and the plan of care, but the member and/or representative chooses to continue to employ the worker, the care coordinator shall note the concern and the member's choice to continue using the worker in the member's plan of care, and shall update the risk assessment and/or risk agreement as needed. The FEA and care coordinator shall collaborate to develop strategies to address identified issues and concerns. The FEA shall inform the member and/or representative of any potential risks associated with continuing to use the worker. The CONTRACTOR shall forward to TENNCARE for disposition, pursuant to TennCare policy, any cases in which the CONTRACTOR plans to disenroll the member from consumer direction because a care coordinator has determined that the health, safety and welfare of the member may be in jeopardy if the member continues to employ a worker but the member and/or representative does not want to terminate the worker. The CONTRACTOR and FEA shall abide by TENNCARE's decision.
- 2.9.7.6.11 A member shall have the flexibility to choose from a range of TENNCARE specified reimbursement levels for all eligible consumer directed HCBS, excluding companion care services which shall be reimbursed at the rate specified by TENNCARE.
- 2.9.7.6.12 In order to receive payment for services rendered, all workers must:
 - 2.9.7.6.12.1 Deliver services in accordance with the schedule of services specified in the member's plan of care and in the MCO's service authorization, and in accordance with worker assignments determined by the member or his/her representative. The FEA shall input the member/representative's assignment of individual workers into the EVV; and
 - 2.9.7.6.12.2 Maintain and submit documentation of service delivery (i.e., documentation of the tasks and functions performed during the provision of services), and any other documentation, as required, for units of service delivered; and
 - 2.9.7.6.12.3 Provide no more than forty (40) hours of services within a consecutive seven (7) day period, unless explicitly permitted by program guidelines and in accordance with service authorizations.
- 2.9.7.6.13 The FEA shall enter worker schedules into the EVV system in accordance with the CONTRACTOR's guidelines and the schedule at which services are needed by the member, based on the member's plan of care and the CONTRACTOR's service authorization.

2.9.7.7 Training

2.9.7.7.1 The CONTRACTOR shall require all members electing to enroll in consumer direction of HCBS and/or their representatives to receive relevant training. The FEA shall be responsible for providing or arranging for initial and ongoing training of members/representatives. When training is not directly provided by the FEA, the FEA shall validate completion of training. Initial training shall be completed prior to initiation of consumer directed services.

2.9.7.7.2 At a minimum, consumer direction training for members and/or representatives shall address the following issues:

2.9.7.7.2.1 Understanding the role of members and representatives in consumer direction;

2.9.7.7.2.2 Understanding the role of the care coordinator and the FEA;

2.9.7.7.2.3 Selecting workers;

2.9.7.7.2.4 Abuse and neglect prevention and reporting;

2.9.7.7.2.5 Being an employer, evaluating worker performance and managing workers;

2.9.7.7.2.6 Fraud and abuse prevention and reporting;

2.9.7.7.2.7 Performing administrative tasks such as reviewing and approving electronically captured visit information; and

2.9.7.7.2.8 Scheduling workers and back-up planning.

2.9.7.7.3 Ongoing training shall be provided by the FEA to members and/or representatives upon request and/or if a care coordinator or FEA, through monitoring, determines that additional training is warranted.

2.9.7.7.4 The FEA shall be responsible for providing or arranging for initial and ongoing training of all workers. When training is not directly provided by the FEA, the FEA shall validate completion of training. Initial training shall be completed prior to initiation of services. At a minimum, training shall consist of the following required elements:

2.9.7.7.4.1 Overview of the CHOICES program and consumer direction of HCBS;

2.9.7.7.4.2 Caring for elderly and disabled populations;

2.9.7.7.4.3 Abuse and neglect identification and reporting;

2.9.7.7.4.4 CPR and first aid certification;

2.9.7.7.4.5 Critical incident reporting;

2.9.7.7.4.6 Submission of required documentation and withholdings;

- 2.9.7.7.4.7 Use of the EVV system; and
- 2.9.7.7.4.8 As appropriate, administration of self-directed health care task(s).
- 2.9.7.7.5 The FEA shall assist the member/representative in determining to what extent the member/representative shall be involved in the above-specified training. The member/ representative shall provide additional training to the worker regarding individualized service needs and preference.
- 2.9.7.7.6 The FEA shall verify that workers have successfully completed all required training prior to service initiation and payment for services.
- 2.9.7.7.7 Ongoing, the FEA shall ensure that workers maintain CPR and first aid certification and receive required refresher training as a condition of continued employment and shall arrange for the appropriate training. Additional training components may be provided to a worker to address issues identified by the FEA, care coordinator, member and/or the representative or at the request of the worker.
- 2.9.7.7.8 Refresher training may be provided more frequently if determined necessary by the FEA, care coordinator, member and/or representative or at the request of the worker.
- 2.9.7.8 Monitoring
- 2.9.7.8.1 The CONTRACTOR shall monitor the quality of service delivery and the health, safety and welfare of members participating in consumer direction through the CHOICES care coordination functions.
- 2.9.7.8.2 The CONTRACTOR shall monitor for late or missed visits by consumer-directed workers.
- 2.9.7.8.3 The CONTRACTOR shall require that the EVV system include functionality to provide prompt (i.e., “real time”) notification 24 hours/day, 7 days/week via automated email, as defined in business rules, to the MCO and to the FEA if a consumer-directed worker does not arrive as scheduled, or otherwise deviates from the authorized schedule so that gaps in care are immediately identified and addressed. Alerts will be provided via email, the monitoring alert dashboard, and text messaging.
- 2.9.7.8.4 The CONTRACTOR shall monitor implementation of the back-up plan by the member or his/her representative, with assistance provided to the member/representative by the FEA Supports Broker as needed.
- 2.9.7.8.5 The CONTRACTOR shall monitor a member’s participation in consumer direction of HCBS to determine, at a minimum, the success and the viability of the service delivery model for the member. The CONTRACTOR shall note any patterns, such as frequent turnover of representatives and changing between consumer direction of HCBS and contract providers that may warrant intervention by the CONTRACTOR. The CONTRACTOR may submit a request to TENNCARE, pursuant to TennCare policy, to involuntarily withdraw the member from consumer direction of HCBS if the CONTRACTOR has concerns about its ability to protect the health, safety and welfare of the member (see Section 2.9.7.9.4).

- 2.9.7.8.6 If at any time abuse or neglect is suspected, the member's care coordinator or the FEA shall report the allegations to the CONTRACTOR within 24 hours in accordance with the abuse and neglect plan protocols developed by the CONTRACTOR. The notification shall include at a minimum: the member name; date of allegation reported and/or identified; description of issue; measures taken to mitigate risk; status of reporting to CPS or APS, as appropriate. If the allegation is in reference to a worker or representative, the FEA shall contact the member/representative to immediately release the worker or representative from his/her duties until the investigation is complete. The FEA shall notify the CONTRACTOR regarding this communication with the member/representative and the member or representative's decision. The care coordinator shall work with the member to find a new representative and the FEA shall work with the member to find a suitable replacement worker, if applicable. If the allegations are substantiated as a result of the investigation, the representative and/or worker shall no longer be allowed to participate in the CHOICES program in any capacity. If the investigation is inconclusive, the member may elect to retain the worker or representative. The member's care coordinator, with appropriate assistance from the FEA, shall make any updates to the member's plan of care and/or risk assessment/risk agreement deemed necessary to help ensure the member's health and safety, and the CONTRACTOR may initiate action to involuntary disenroll the member from consumer direction at any time the CONTRACTOR feels that the member's decisions or actions constitute unreasonable risk such that the member's needs can no longer be safely and effectively met in the community while participating in consumer direction.
- 2.9.7.9 Withdrawal from Consumer Direction of HCBS
- 2.9.7.9.1 A member may voluntarily withdraw from consumer direction of HCBS at any time. The member and/or representative shall notify the care coordinator as soon as he/she determines that he/she is no longer interested in participating in consumer direction of HCBS.
- 2.9.7.9.2 Upon receipt of a member's request to withdraw from consumer direction of HCBS, the CONTRACTOR shall conduct a face-to-face visit and update the member's plan of care, as appropriate, to initiate the process to transition the member to contract providers.
- 2.9.7.9.3 In the event that the FEA or care coordinator has concerns that a worker is unable to deliver appropriate care as prescribed in the service agreement and the plan of care, but the member and/or representative chooses to continue to employ the worker, note the concern and the member's choice to continue using the worker in the member's plan of care, and shall update the risk assessment and/or risk agreement as needed.
- 2.9.7.9.4 The CONTRACTOR shall forward to TENNCARE for disposition, pursuant to TennCare policy, any cases in which the CONTRACTOR plans to disenroll a member from consumer direction. The CONTRACTOR may initiate involuntary withdrawal of a member from consumer direction of HCBS:

- 2.9.7.9.4.1 If a member's representative fails to perform in accordance with the terms of the representative agreement and the health, safety and welfare of the member is at risk, and the member wants to continue to use the representative.
- 2.9.7.9.4.2 If a member has consistently demonstrated that he/she is unable to manage, with sufficient supports (including appointment of a representative) his/her services and the care coordinator or FEA has identified health, safety and/or welfare issues.
- 2.9.7.9.4.3 A care coordinator has determined that the health, safety and welfare of the member may be in jeopardy if the member continues to employ a worker but the member and/or representative does not want to terminate the worker.
- 2.9.7.9.4.4 Other significant concerns regarding the member's participation in consumer direction which jeopardize the health, safety or welfare of the member.
- 2.9.7.9.5 If TENNCARE approves the CONTRACTOR's request, the CONTRACTOR shall notify the member in accordance with TennCare rules and regulations, and the member shall have the right to appeal the determination (see Section 2.19.3.12 of this Agreement).
- 2.9.7.9.6 The CONTRACTOR, in conjunction with the FEA, shall facilitate a seamless transition from workers to contract providers and ensure there are no interruptions or gaps in services.
- 2.9.7.9.7 Voluntary or involuntary withdrawal of a member from consumer direction of HCBS shall not affect a member's eligibility for long-term care services or enrollment in CHOICES.
- 2.9.7.9.8 The CONTRACTOR shall notify the FEA within one business day of processing the enrollment file when a member voluntarily withdraws from consumer direction of HCBS, when a member is involuntarily withdrawn from consumer direction of HCBS, and when a member is disenrolled from CHOICES or from TennCare. The notification should include the effective date of withdrawal and/or disenrollment, as applicable.
- 2.9.7.9.9 Members who have been involuntarily withdrawn may request to be reinstated in consumer direction of HCBS. The care coordinator shall work with the FEA to ensure that the issues previously identified as reasons for withdrawal have been adequately addressed prior to reinstatement. All members shall be required to participate in consumer direction training programs prior to re-instatement in consumer direction of HCBS.
- 2.9.7.10 Claims Submission and Payment
- 2.9.7.10.1 The CONTRACTOR shall ensure that the EVV system creates and makes available to the FEA on at least a daily basis an electronic claims submission file in the 837 format, including exceptions which have been resolved, which may be submitted to the CONTRACTOR for claims processing at the appropriate frequency.

- 2.9.7.10.2 The CONTRACTOR shall reimburse the FEA for authorized HCBS provided by workers at the appropriate rate for the consumer directed services, which includes applicable payroll taxes.
- 2.9.7.10.3 The CONTRACTOR shall process and pay claims submitted by the FEA within fourteen (14) calendar days of receipt.

2.9.8 **Coordination and Collaboration for Members with Behavioral Health Needs**

2.9.8.1 General

As provided in Section 2.6.1 of this Agreement, the CONTRACTOR shall be responsible for providing a full continuum of physical health, behavioral health, and long-term care services. The CONTRACTOR shall also be responsible for ensuring continuity and coordination between covered physical health, behavioral health, and long-term care services and ensuring collaboration between physical health, behavioral health, and long-term care providers. The CONTRACTOR shall develop policies and procedures that address key elements in meeting this requirement. These elements include, but are not limited to, screening for behavioral health needs (including the screening tool), referral to physical health and behavioral health providers, screening for long-term care needs, exchange of information, confidentiality, assessment, treatment plan and plan of care development and implementation, collaboration, MCO case management, care coordination (for CHOICES members) and disease management, provider training, and monitoring implementation and outcomes.

2.9.8.2 Subcontracting for Behavioral Health Services

If the CONTRACTOR subcontracts for the provision of behavioral health services, the CONTRACTOR shall develop and implement a written agreement with the subcontractor regarding the coordination of services provided by the CONTRACTOR and those provided by the subcontractor. The agreement shall address the responsibilities of the CONTRACTOR and the subcontractor regarding, at a minimum, the items identified in Section 2.9.8.1 as well as prior authorization, claims payment, claims resolution, contract disputes, and reporting. The subcontract shall comply with all of the requirements regarding subcontracts included in Section 2.26 of this Agreement.

2.9.8.3 Screening for Behavioral Health Needs

- 2.9.8.3.1 The CONTRACTOR shall ensure that the need for behavioral health services is systematically identified by and addressed by the member's PCP at the earliest possible time following initial enrollment of the member in the CONTRACTOR's MCO or after the onset of a condition requiring mental health and/or substance abuse treatment.
- 2.9.8.3.2 The CONTRACTOR shall encourage PCPs and other providers to use a screening tool prior approved in writing by the State as well as other mechanisms to facilitate early identification of behavioral health needs.

2.9.8.3.3 As part of the care coordination process (see Section 2.9.6), the CONTRACTOR shall ensure that behavioral health needs of CHOICES members are identified and addressed.

2.9.8.4 Referrals to Behavioral Health Providers

The CONTRACTOR shall ensure through screening that members with a need for behavioral health services, particularly members with SED/SPMI are appropriately referred to behavioral health providers. The CONTRACTOR shall develop provider education and training materials to ensure that physical health and long-term care providers know when and how to refer members who need specialty behavioral health services. This shall include education about behavioral health services, including the recovery process and resilience for children. The CONTRACTOR shall develop a referral process to be used by its providers, including what information must be exchanged and when to share this information, as well as notification to the member's care coordinator.

2.9.8.5 Referrals to PCPs

The CONTRACTOR shall ensure that members with both physical health and behavioral health needs are appropriately referred to their PCPs for treatment of their physical health needs. The CONTRACTOR shall develop provider education and training materials to ensure that behavioral health providers know when and how to refer members who need physical health services. The CONTRACTOR shall develop a referral process to be used by its providers. The referral process shall include providing a copy of the physical health consultation and results to the behavioral health provider.

2.9.8.6 Referrals to CHOICES

The CONTRACTOR shall ensure that members with both long-term care and behavioral health needs are referred to the CONTRACTOR for CHOICES intake (see Section 2.9.6.3). The CONTRACTOR shall develop provider education and training materials to ensure that behavioral health providers know when and how to refer members who need long-term care services to the CONTRACTOR.

2.9.8.7 Behavioral Health Assessment and Treatment Plan

The CONTRACTOR's policies and procedures shall identify the role of physical health and behavioral health providers in assessing a member's behavioral health needs and developing an individualized treatment plan. For members with chronic physical conditions that require ongoing treatment who also have behavioral health needs, the CONTRACTOR shall encourage participation of both the member's physical health provider (PCP or specialist) and behavioral health provider in the assessment and individualized treatment plan development process as well as the ongoing provision of services. For members in CHOICES Groups 2 and 3 with behavioral health needs, the member's care coordinator shall encourage participation of the member's behavioral health provider in the care planning process and shall incorporate relevant information from the member's behavioral health treatment plan (see Section 2.7.2.1.4) in the member's plan of care (see Section 2.9.6.6).

2.9.8.8 MCO Case Management, Disease Management, and CHOICES Care Coordination

The CONTRACTOR shall use its MCO case management, disease management, and CHOICES care coordination programs (see Sections 2.9.5, 2.8, and 2.9.6) to support the continuity and coordination of covered physical health, behavioral health, and long-term care services and the collaboration between physical health, behavioral health, and long-term care providers. The CONTRACTOR has the option to allow members, e.g., members who have been determined to be high risk based on disease management stratification (see Section 2.8.3), to be enrolled in both a disease management program and MCO case management. For CHOICES members, MCO case management and/or disease management activities shall be integrated with the care coordination process (see Sections 2.9.5.4, and 2.9.6.1.8).

2.9.8.9 Monitoring

The CONTRACTOR shall evaluate and monitor the effectiveness of its policies and procedures regarding the continuity and coordination of covered physical, behavioral health, and long-term care services and collaboration between physical health, behavioral health, and long-term care providers. This shall include, but not be limited to, an assessment of the appropriateness of the diagnosis, treatment, and referral of behavioral health disorders commonly seen by PCPs; an evaluation of the appropriateness of psychopharmacological medication; and analysis of data regarding access to appropriate services. Based on these monitoring activities, the CONTRACTOR shall develop and implement interventions to improve continuity, coordination, and collaboration for physical health, behavioral health, and long-term care services.

2.9.9 **Coordination and Collaboration Among Behavioral Health Providers**

2.9.9.1 The CONTRACTOR shall ensure communication and coordination between mental health providers and substance abuse providers, including:

2.9.9.1.1 Assignment of a responsible party to ensure communication and coordination occur;

2.9.9.1.2 Determination of the method of mental health screening to be completed by substance abuse service providers; screening and assessment tools to be designated by TENNCARE;

2.9.9.1.3 Determination of the method of substance abuse screening to be completed by mental health service providers; screening and assessment tools to be designated by TENNCARE;

2.9.9.1.4 Description of how treatment plans will be coordinated between behavioral health service providers; and

2.9.9.1.5 Assessment of cross training of behavioral health providers: mental health providers being trained on substance abuse issues and substance abuse providers being trained on mental health issues.

2.9.9.2 The CONTRACTOR shall ensure coordination between the children and adolescent service delivery system as they transition into the adult mental health service delivery

system, through such activities as communicating treatment plans and exchange of information.

- 2.9.9.3 The CONTRACTOR shall coordinate inpatient and community services, including the following requirements related to hospital admission and discharge:
 - 2.9.9.3.1 The outpatient provider shall be involved in the admissions process when possible; if the outpatient provider is not involved, the outpatient provider shall be notified promptly of the member's hospital admission;
 - 2.9.9.3.2 Psychiatric hospital and residential treatment facility discharges shall not occur without a discharge plan in which the member has participated (an outpatient visit shall be scheduled before discharge, which ensures access to proper provider/medication follow-up; also, an appropriate placement or housing site shall be secured prior to discharge);
 - 2.9.9.3.3 An evaluation shall be performed prior to discharge to determine if mental health case management services are medically necessary. Once deemed medically necessary, the mental health case manager shall be involved in discharge planning; if there is no mental health case manager, then the outpatient provider shall be involved; and
 - 2.9.9.3.4 A procedure to ensure continuity of care regarding medication shall be developed and implemented.
- 2.9.9.4 The CONTRACTOR shall identify and develop community alternatives to inpatient hospitalization for those members who are receiving inpatient psychiatric facility services who could leave the facility if appropriate community or residential care alternatives were available in the community. In the event the CONTRACTOR does not provide appropriate community alternatives, the CONTRACTOR shall remain financially responsible for the continued inpatient care of these individuals.
- 2.9.9.5 The CONTRACTOR is responsible for providing a discharge plan as outlined in Section 2.9.9.3.2.

2.9.10 Coordination of Pharmacy Services

- 2.9.10.1 Except as provided in Section 2.6.1.3, the CONTRACTOR is not responsible for the provision and payment of pharmacy benefits; TENNCARE contracts with a pharmacy benefits manager (PBM) to provide these services. However, the CONTRACTOR shall coordinate with the PBM as necessary to ensure that members receive appropriate pharmacy services without interruption. The CONTRACTOR shall monitor and manage its contract providers as it relates to prescribing patterns and its members as it relates to utilization of prescription drugs. The CONTRACTOR shall participate in regularly scheduled meetings with the PBM and TENNCARE to discuss operational and programmatic issues.
- 2.9.10.2 The CONTRACTOR shall accept and maintain prescription drug data from TENNCARE or its PBM.

- 2.9.10.3 The CONTRACTOR shall monitor and manage members by, at a minimum, conducting the activities as described below:
 - 2.9.10.3.1 Analyzing prescription drug data and/or reports provided by the PBM or TENNCARE to identify high-utilizers and other members who inappropriately use pharmacy services and assign them to MCO case management and/or disease management programs and/or refer them to CHOICES intake (see Section 2.9.6) as appropriate; if a CHOICES member is identified as a high-utilizer or as inappropriately using pharmacy services, relevant prescription drug data and/or reports for the member shall be provided to the member's care coordinator, and the care coordinator shall take appropriate next steps, which may include coordination with the member's PCP;
 - 2.9.10.3.2 Analyzing prescription drug data and/or reports provided by the PBM to identify potential pharmacy lock-in candidates and referring them to TENNCARE; and
 - 2.9.10.3.3 Regularly providing information to members about appropriate prescription drug usage. At a minimum, this information shall be included in the Member Handbook and in at least two (2) quarterly member newsletters within a twelve (12) month period.
- 2.9.10.4 The CONTRACTOR shall monitor and manage providers' prescription patterns by, at a minimum, conducting the activities described below:
 - 2.9.10.4.1 Collaborating with the PBM to educate the MCO's contract providers regarding compliance with the State's preferred drug list (PDL) and appropriate prescribing practices; and
 - 2.9.10.4.2 Intervening with contract providers whose prescribing practices appear to be operating outside industry or peer norms as defined by TENNCARE, are non-compliant as it relates to adherence to the PDL and/or generic prescribing patterns, and/or who are failing to follow required prior authorization processes and procedures. The goal of these interventions will be to improve prescribing practices among the identified contract providers, as appropriate. Interventions shall be personal and one-on-one.
- 2.9.10.5 At any time, upon request from TENNCARE, the CONTRACTOR shall provide assistance in educating, monitoring and intervening with providers. For example, TENNCARE may require assistance in monitoring and intervening with providers regarding prescribing patterns for narcotics.

2.9.11 Coordination of Dental Benefits

- 2.9.11.1 General
 - 2.9.11.1.1 The CONTRACTOR is not responsible for the provision and payment of dental benefits; TENNCARE contracts with a dental benefits manager (DBM) to provide these services.

2.9.11.1.2 As provided in Section 2.6.1.3, the CONTRACTOR is responsible for transportation to and from dental services as well as the facility, medical and anesthesia services related to medically necessary and approved dental services that are not provided by a dentist or in a dentist's office.

2.9.11.1.3 The CONTRACTOR may require prior authorization for services related to dental services including the facility, anesthesia, and/or medical services related to the dental service. However, the CONTRACTOR may waive authorization of said services based upon authorization of the dental services by the dental benefits manager. The CONTRACTOR shall approve and arrange transportation to and from dental services in accordance with this Agreement, including but not limited to Attachment XI.

2.9.11.2 Services and Responsibilities

The CONTRACTOR shall coordinate with the DBM and/or the ID HCBS waiver contractor for dental services. Coordination of dental services, at a minimum, includes establishing processes for:

2.9.11.2.1 Means for referral that ensures immediate access for emergency care and provision of urgent and routine care according to TennCare guidelines for specialty care (see Attachment III);

2.9.11.2.2 Means for the transfer of information (to include items before and after the visit);

2.9.11.2.3 Maintenance of confidentiality;

2.9.11.2.4 Resolving disputes related to prior authorizations and claims and payment issues; and

2.9.11.2.5 Cooperation with the DBM regarding training activities provided by the DBM.

2.9.11.3 Operating Principles

Coordinating the delivery of dental services to TennCare members is the primary responsibility of the DBM and/or the ID HCBS waiver contractor. However, the CONTRACTOR shall provide coordination assistance and shall be responsible for communicating the DBM/HCBS provider services, provider relations, and/or claim coordinator contact information to all of its contract providers. With respect to specific member issues, the CONTRACTOR shall work with the DBM/HCBS coordinator towards a resolution. Should systemic issues arise, the CONTRACTOR shall meet and resolve the issues with the DBM/HCBS waiver contractor. In the event that such issues cannot be resolved, the MCO and the DBM/HCBS waiver contractor shall meet with TENNCARE to reach final resolution of matters involved. Final resolution of system issues shall occur within ninety (90) calendar days from referral to TENNCARE.

2.9.11.4 Resolution of Requests for Prior Authorization

2.9.11.4.1 The CONTRACTOR agrees, and recognizes that the DBM has agreed through its contractual arrangement with the State, that any dispute concerning which party should respond to a request for prior authorization shall not cause a denial, delay,

reduction, termination or suspension of any appropriate service to a TennCare enrollee. The CONTRACTOR shall require that its DBM care coordinators will, in addition to their responsibilities for DBM care coordination, deal with issues related to requests for prior authorization that require coordination between the DBM and the CONTRACTOR. The CONTRACTOR shall provide the DBM with a list of its DBM care coordinators and telephone number(s) at which each DBM care coordinator may be contacted. When the CONTRACTOR receives a request for prior authorization from a provider for a member and the CONTRACTOR believes the service is the responsibility of the DBM, the CONTRACTOR's DBM care coordinator shall contact the DBM's care coordinator by the next business day after receiving the request for prior authorization. The DBM care coordinator shall also contact the member and/or member's provider. For routine requests contact to the member or member's provider shall be made within fourteen (14) days or less of the provider's request for prior authorization and shall comply with all applicable consent decrees and court orders and TennCare rules and regulations. For urgent requests, contact shall be made immediately after receiving the request for prior authorization.

2.9.11.4.2 The CONTRACTOR shall assign staff members to serve on a coordination committee with DBM staff members. This committee shall be responsible for addressing all issues of dental care coordination. The committee will review disputes regarding clinical care and provide a clinical resolution to the dispute, subject to the terms of this Agreement. The CONTRACTOR and the DBM shall attempt in good faith to resolve any dispute and communicate the decision to the provider requesting prior authorization of a service. In the event the CONTRACTOR and the DBM cannot agree within ten (10) calendar days of the provider's request for prior authorization, the party who first received the request from the provider shall be responsible for prior authorization and payment to the contract provider within the time frames designated by TENNCARE. The CONTRACTOR and the DBM are responsible for enforcing hold harmless protection for the member. The CONTRACTOR shall ensure that any response to a request for authorization shall not exceed fourteen (14) calendar days and shall comply with all applicable consent decrees and court orders and TennCare rules and regulations.

2.9.11.5 Claim Resolution Processes

2.9.11.5.1 The CONTRACTOR shall designate one or more claims coordinators to deal with issues related to claims and payment issues that require coordination between the DBM and the CONTRACTOR. The CONTRACTOR agrees and recognizes that the DBM has agreed through its contractual arrangement with the State, to also designate one or more claims coordinators to deal with issues related to claims and payment issues that require coordination between the DBM and the CONTRACTOR. The CONTRACTOR shall provide the DBM and TennCare, with a list of its claims coordinators and telephone number(s) at which each claims coordinator may be contacted.

2.9.11.5.2 When the CONTRACTOR receives a disputed claim for payment from a provider for a member and believes care is the responsibility of the DBM, the CONTRACTOR's claims coordinators shall contact the DBM's claims coordinators within four (4) calendar days of receiving such claim for payment. If the CONTRACTOR's claims coordinator is unable to reach agreement with the DBM's claims coordinators on

which party is responsible for payment of the claim, the claim shall be referred to the Claims Coordination Committee (described below) for review.

- 2.9.11.5.3 The CONTRACTOR shall assign claims coordinators and other representatives, as needed, to a joint CONTRACTOR/DBM Claims Coordination Committee. The number of members serving on the Claims Coordination Committee shall be determined within ten (10) calendar days of the execution of this Agreement by the mutual agreement of the DBM and MCO. The CONTRACTOR shall, at a minimum, assign two (2) representatives to the committee. The make-up of the committee may be revisited from time to time during the term of this Agreement. The Claims Coordination Committee shall review any disputes and negotiate responsibility between the CONTRACTOR and the DBM. Unless otherwise agreed, such meeting shall take place within ten (10) calendar days of receipt of the initial disputed claim or request from the provider. If resolution of the claim results in the party who assumed responsibility for authorization and payment having no liability, the other party shall reimburse and abide by the prior decisions of that party. Reimbursement shall be made within ten (10) calendar days of the Claims Coordination Committee's decision.
- 2.9.11.5.4 If the Claims Coordination Committee cannot reach an agreement as to the proper division of financial responsibility within ten (10) calendar days of the initial referral to the Claims Coordination Committee, said claim shall be referred to both the CONTRACTOR's and the DBM's CEO or the CEO's designee, for resolution immediately. A meeting shall be held among the CEOs or their designee(s) as soon as possible, but not longer than ten (10) calendar days after the meeting of the Claims Coordination Committee.
- 2.9.11.5.5 If the meeting between the CEOs, or their designee(s), of the DBM and MCO does not successfully resolve the dispute within ten (10) calendar days, the parties shall, within fourteen (14) calendar days of the meeting, submit a Request for Resolution of the dispute to the State or the State's designee for a decision on responsibility.
- 2.9.11.5.6 The process before the submission of a Request for Resolution, as described above, shall be completed within thirty (30) calendar days of receiving the claim for payment. In the event the parties cannot agree within thirty (30) calendar days of receiving the claim for payment, the MCO and the DBM shall be responsible for enforcing hold harmless protections for the member and the party who first received the request or claim from the provider shall be responsible for authorization and payment to the provider in accordance with the requirements of the MCO's or DBM's respective Agreement/contract with the State of Tennessee. Moreover, the party that first received the request or claim from the provider shall also make written request of all requisite documentation for payment and shall provide written reasons for any denial.
- 2.9.11.5.7 The Request for Resolution shall contain a concise description of the facts regarding the dispute, the applicable Agreement/contract provisions, and the position of the party making the request. A copy of the Request for Resolution shall also be delivered to the other party. The other party shall then submit a Response to the Request for Resolution within fifteen (15) calendar days of the date of the Request for Resolution. The Response shall contain the same information required of the

Request for Resolution. Failure to timely file a Response or obtain an extension from the State shall be deemed a waiver of any objections to the Request for Resolution.

2.9.11.5.8 The State or its designee shall make a decision in writing regarding who is responsible for the payment of services within ten (10) calendar days of the receipt of the required information (“Decision”). The Decision may reflect a split payment responsibility that designates specific proportions to be paid by the MCO and the DBM. The Decision shall be determined solely by the State or its designee based on specific circumstances regarding each individual case. Within five (5) business days of receipt of the Decision, the non-successful party shall reimburse any payments made by the successful party for the services. The non-successful party shall also pay to the State, within thirty (30) calendar days of the Decision, an administrative fee equal to ten percent (10%) of the value of the claims paid, not to exceed one-thousand dollars (\$1,000), for each Request for Resolution. The amount of the DBM’s or MCO’s payment responsibility shall be contained in the State’s Decision. These payments may be made with reservation of rights regarding any judicial resolution. If a party fails to pay the State for the party’s payment responsibility as described in this Section, Section 2.9.11.5.8, within thirty (30) calendar days of the date of the State’s Decision, the State may deduct amounts of the payment responsibility from any current or future amount owed the party by the State.

2.9.11.6 Denial, Delay, Reduction, Termination or Suspension

The CONTRACTOR agrees that any claims payment dispute or request for authorization shall not cause a denial, delay, reduction, termination or suspension of any appropriate services to a TennCare member. In the event there is a claim for emergency services, the party receiving a request for authorization to treat any member shall insure that the member is treated immediately and payment for the claim shall be approved or disapproved based on the definition of emergency services specified in this Agreement.

2.9.11.7 Emergencies

Prior authorization shall not be required for emergency services prior to stabilization.

2.9.11.8 Claims Processing Requirements

All claims shall be processed in accordance with the requirements of the MCO’s and DBM’s respective Agreements/contracts with the State of Tennessee.

2.9.11.9 Appeal of Decision

Appeal of any Decision shall be to a court or commission of competent jurisdiction and shall not constitute a procedure under the Administrative Procedure Act, TCA 4-5-201 *et seq.* Exhaustion of the above-described process shall be required before filing of any claim or lawsuit on issues covered by this Section, Section 2.9.11.9

2.9.11.10 Duties and Obligations

The existence of any dispute under this Agreement shall in no way affect the duty of the CONTRACTOR and the DBM to continue to perform their respective

obligations, including their obligations established in their respective Agreements/contracts with the State pending resolution of the dispute under this Section, Section 2.9.11.10. In accordance with TCA 56-32-126(b), a provider may elect to resolve the claims payment dispute through independent review.

2.9.11.11 Confidentiality

2.9.11.11.1 The CONTRACTOR agrees, and recognizes that the DBM has agreed through its contractual arrangement with the State, to cooperate with the State to develop confidentiality guidelines that (1) meet state, federal, and other regulatory requirements; (2) meet the requirements of the professions or facilities providing care and maintaining records; and (3) meet both DBM and MCO standards. These standards shall apply to both DBM's and MCO's providers and staff. If the CONTRACTOR or DBM believes that the standards require updating, or operational changes are needed to enforce the standards, the CONTRACTOR shall meet with the DBM to resolve these issues. Such standards shall provide for the exchange of confidential e-mails to ensure the privacy of the members.

2.9.11.11.2 The DBM and MCO shall ensure all materials and information directly or indirectly identifying any current or former member which is provided to or obtained by or through the MCO's or DBM's performance of this Agreement, whether verbal, written, tape, or otherwise, shall be maintained in accordance with the standards of confidentiality of TCA 33-4-22, Section 5.33 of this Agreement, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and, unless required by applicable law, shall not be disclosed except in accordance with those requirements or to TENNCARE, and CMS, or their designees. Nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form that does not identify any current or former member or potential member.

2.9.11.12 Access to Service

The CONTRACTOR agrees and recognizes that the DBM has agreed through its contractual arrangement with the State, to establish methods of referral which ensure immediate access to emergency care and the provision of urgent and routine care in accordance with TennCare guidelines.

2.9.12 Coordination with Medicare

2.9.12.1 The CONTRACTOR is responsible for providing medically necessary covered services to members who are also eligible for Medicare if the service is not covered by Medicare.

2.9.12.2 The CONTRACTOR shall ensure that services covered and provided pursuant to this Agreement are delivered without charge to members who are dually eligible for Medicare and Medicaid services.

2.9.12.3 The CONTRACTOR shall coordinate with Medicare payers, Medicare Advantage plans, and Medicare providers as appropriate to coordinate the care and benefits of members who are also eligible for Medicare.

2.9.13 ICF/MR Services and Alternatives to ICF/MR Services

- 2.9.13.1 The CONTRACTOR is not responsible for services in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or for services provided through Home and Community Based Services (HCBS) waivers as an alternative to ICF/MR services (hereinafter referred to as “HCBS MR waiver”). However, to the extent that services available to a member through a HCBS MR waiver are also covered services pursuant to this Agreement, the CONTRACTOR shall be responsible for providing all medically necessary covered services. HCBS MR waiver services may supplement, but not supplant, medically necessary covered services. ICF/MR services and HCBS MR waiver services shall be provided to qualified members as described in TennCare rules and regulations through contracts between TENNCARE and appropriate providers.
- 2.9.13.2 The CONTRACTOR is responsible for covered services for members residing in an ICF/MR or enrolled in a HCBS MR waiver. For members residing in an ICF/MR, the CONTRACTOR is responsible for providing covered services that are not included in the per diem reimbursement for institutional services (e.g., prosthetics, some items of durable medical equipment, non-emergency ambulance transportation, and non-emergency transportation). Except as provided below for NEMT, for members enrolled in a HCBS MR waiver, the CONTRACTOR shall provide all medically necessary covered services, including covered services that may also be provided through the HCBS MR waiver. The HCBS MR waiver is the payor of last resort. However, the CONTRACTOR is not responsible for providing non-emergency medical transportation (NEMT) to any service that is being provided to the member through the HCBS MR waiver.
- 2.9.13.3 The CONTRACTOR shall coordinate the provision of covered services with services provided by ICF/MR and HCBS MR waiver providers to minimize disruption and duplication of services.

2.9.14 Enrollees with Special Health Care Needs

- 2.9.14.1 The CONTRACTOR shall implement mechanisms to assess each TennCare enrollee identified by the State as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals. Enrollees who are dually eligible for TennCare and Medicare are exempt from this requirement. For purposes of Section 2.9.13, enrollees with special health care needs shall refer to enrollees in the custody of the Department of Children’s Services (DCS), as described in Section 1 of this Agreement.
- 2.9.14.2 The CONTRACTOR shall implement procedures to share, with other MCOs, DBMs and PBMs (as necessary) serving the enrollee, the results of its identification and assessment of any enrollee with special health care needs so that those activities need not be duplicated.

2.9.15 Inter-Agency Coordination

The CONTRACTOR shall coordinate with other state and local departments and agencies to ensure that coordinated care is provided to members. This includes, but is not limited to, coordination with:

- 2.9.15.1 Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) for the purpose of interfacing with and assuring continuity of care and for coordination of specialized services in accordance with federal PASRR requirements;
- 2.9.15.2 Tennessee Department of Children's Services (DCS) for the purpose of interfacing with, assuring continuity of care, and assuring the provision of covered services to children in or transitioning out of State custody;
- 2.9.15.3 Tennessee Department of Health (DOH), for the purposes of establishing and maintaining relationships with member groups and health service providers;
- 2.9.15.4 Tennessee Department of Human Services (DHS) and DCS Protective Services Section, for the purposes of reporting and cooperating in the investigation of abuse and neglect;
- 2.9.15.5 The Division of Intellectual Disabilities Services (DIDS), for the purposes of interfacing with and assuring continuity of care and for coordination of specialized services in accordance with federal PASRR requirements;
- 2.9.15.6 Area Agencies on Aging and Disability (AAADs) regarding intake of members new to both TennCare and CHOICES, assisting members in CHOICES Groups 2 and 3 with the TennCare eligibility redetermination process, and facilitating the transition of members in CHOICES Group 2 during CHOICES implementation and when members in CHOICES Group 2 are moving to a Grand Region where CHOICES has not yet been implemented;
- 2.9.15.7 Tennessee Commission on Aging and Disability (TCAD) regarding TCAD's role in monitoring the performance of the AAADs in conducting SPOE functions;
- 2.9.15.8 Tennessee Department of Education (DOE) and local education agencies for the purposes of coordinating educational services in compliance with the requirements of Individuals with Disabilities Education Act (IDEA) and to ensure school-based services for students with special needs are provided;
- 2.9.15.8.1 The CONTRACTOR is responsible for the delivery of medically necessary covered services to school-aged children. MCOs are encouraged to work with school-based providers to manage the care of students with special needs. The State has implemented a process, referred to as TENNderCARE Connection, to facilitate notification of MCOs when a school-aged child enrolled in TennCare has an Individualized Education Plan (IEP) that identifies a need for medical services. In such cases, the school is responsible for obtaining parental consent to share the IEP with the MCO and for subsequently sending a copy of the parental consent and IEP to the MCO. The school is also responsible for clearly delineating the services on the IEP that the MCOs are to consider for payment. If a school-aged member, needing

medical services, is identified by the CONTRACTOR by another means, the CONTRACTOR shall request the IEP from the appropriate school system.

2.9.15.8.2 The CONTRACTOR shall designate a contact person to whom correspondence concerning children with medical services included in their IEPs will be directed. After receipt of an IEP, the CONTRACTOR shall:

2.9.15.8.2.1 Either accept the IEP as indication of a medical problem and treat the IEP as a request for service or assist in making an appointment to have the child evaluated by the child's PCP or another contract provider. If the CONTRACTOR does not accept the documentation provided with the IEP as indication of a medical problem, the CONTRACTOR shall have the child re-evaluated in order to make a decision about the appropriateness of the requested service.

2.9.15.8.2.2 Send a copy of the IEP and any related information (e.g. action taken by the MCO in response to receipt of the IEP, action the MCO expects the PCP to take) to the PCP.

2.9.15.8.2.3 Notify the designated school contact of the ultimate disposition of the request (e.g. what services have been approved for the child, what arrangements have been made for service delivery) within 14 days of the CONTRACTOR's receipt of the IEP.

2.9.15.9 Local law enforcement agencies and hospital emergency rooms for the purposes of crisis service provider relationships, and the transportation of individuals certified for further assessment for emergency psychiatric hospitalization.

13. Section 2.11 shall be amended by deleting Section 2.11 in its entirety and replacing it with the following and renumbering all references thereto:

2.11 PROVIDER NETWORK

2.11.1 General Provisions

2.11.1.1 The CONTRACTOR shall provide or ensure the provision of all covered services specified in Section 2.6.1 of this Agreement. Accessibility of covered services, including geographic access and appointments and wait times shall be in accordance with the access standards in Attachment III, the Specialty Network Standards in Attachment IV, the Access and Availability for Behavioral Health Services in Attachment V and the requirements herein. These minimum requirements shall not release the CONTRACTOR from the requirement to provide or arrange for the provision of any medically necessary covered service required by its members, whether specified above or not.

2.11.1.2 The CONTRACTOR may provide covered physical health and behavioral health services directly or may enter into written agreements with providers and provider subcontracting entities or organizations that will provide covered physical health and behavioral health services to the members in exchange for payment by the CONTRACTOR for services rendered. The CONTRACTOR shall enter into written

agreements with providers to provide covered long-term care services. The CONTRACTOR shall not directly provide long-term care services.

- 2.11.1.3 When the CONTRACTOR contracts with providers, the CONTRACTOR shall:
 - 2.11.1.3.1 Not execute provider agreements with providers who have been excluded from participation in the Medicare, Medicaid, and/or SCHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with the TennCare program;
 - 2.11.1.3.2 Consider: the anticipated TennCare enrollment; the expected utilization of services, taking into consideration the characteristics of specific TennCare populations included in this Agreement; the number and types of providers required to furnish TennCare services; the number of contract providers who are not accepting new members; and the geographic location of providers and TennCare members, considering distance, travel time, the means of transportation ordinarily used by TennCare members, and whether the location provides physical access for members with disabilities;
 - 2.11.1.3.3 Have in place, written policies and procedures for the selection and retention of providers. These policies and procedures shall not discriminate against particular providers that service high risk populations or specialize in conditions that require costly treatment;
 - 2.11.1.3.4 Not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. The CONTRACTOR's ability to credential providers as well as maintain a separate network and not include any willing provider is not considered discrimination;
 - 2.11.1.3.5 Give affected providers written notice if it declines to include individual or groups of providers in its network; and
 - 2.11.1.3.6 Maintain all provider agreements in accordance with the provisions specified in 42 CFR 438.12, 438.214 and Section 2.12 of this Agreement.
- 2.11.1.4 Section 2.11.1.3 shall not be construed to:
 - 2.11.1.4.1 Require the CONTRACTOR to contract with providers beyond the number necessary to meet the needs of its members and the access standards of this Agreement; however, the CONTRACTOR shall contract with nursing facilities pursuant to the requirements of Section 2.11.6 of this Agreement and, when directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the CONTRACTOR shall contract with at least two (2) providers for each HCBS to cover each county in each Grand Region, as specified in Section 2.11.6.3;
 - 2.11.1.4.2 Preclude the CONTRACTOR from using different reimbursement amounts for different specialties or for different providers in the same specialty; however, the CONTRACTOR shall reimburse long-term care services in accordance with Sections 2.13.4 and 2.13.5; or

- 2.11.1.4.3 Preclude the CONTRACTOR from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members.
- 2.11.1.5 The CONTRACTOR may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient for the following:
 - 2.11.1.5.1 The member's health status, medical, behavioral health, or long-term care, or treatment options, including any alternative treatment that may be self administered;
 - 2.11.1.5.2 Any information the member needs in order to decide among all relevant treatment options;
 - 2.11.1.5.3 The risks, benefits, and consequences of treatment or non-treatment; or
 - 2.11.1.5.4 The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- 2.11.1.6 Prior to including a provider on the *Provider Enrollment File* (see Section 2.30.7.1) and/or paying a provider's claim, the CONTRACTOR shall ensure that the provider has a National Provider Identifier (NPI) Number, where applicable, and has obtained a Medicaid provider number from TENNCARE.
- 2.11.1.7 If a member requests a provider located outside the access standards, and the CONTRACTOR has an appropriate provider within the access requirements who accepts new members, it shall not be considered a violation of the access requirements for the CONTRACTOR to grant the member's request. However, in such cases the CONTRACTOR shall not be responsible for providing transportation for the member to access care from this selected provider, and the CONTRACTOR shall notify the member in writing as to whether or not the CONTRACTOR will provide transportation for the member to seek care from the requested provider.
- 2.11.1.8 If the CONTRACTOR is unable to meet the access standard for a covered service for which the CONTRACTOR is responsible for providing non-emergency transportation to a member, the CONTRACTOR shall provide transportation regardless of whether the member has access to transportation.
 - 2.11.1.8.1 In the event the CONTRACTOR is unable to meet the access standard for adult day care (see Attachment III) for members in CHOICES Group 2 or 3, the CONTRACTOR shall provide and pay for the cost of transportation for the member to the adult day care facility until such time the CONTRACTOR has sufficient provider capacity.
 - 2.11.1.8.2 The CONTRACTOR is not required to provide non-emergency transportation for HCBS, including services provided through a 1915(c) waiver program for persons with intellectual disabilities (i.e., mental retardation) and HCBS provided through the CHOICES program, except as provided in Section 2.11.1.8.1 above.

- 2.11.1.9 If the CONTRACTOR is unable to provide medically necessary covered services to a particular member using contract providers, the CONTRACTOR shall adequately and timely cover these services for that member using non-contract providers, for as long as the CONTRACTOR's provider network is unable to provide them. At such time that the required services become available within the CONTRACTOR's network and the member can be safely transferred, the CONTRACTOR may transfer the member to an appropriate contract provider as specified in Section 2.9.4.
- 2.11.1.10 The CONTRACTOR shall monitor provider compliance with access requirements specified in Attachment III, including but not limited to appointment and wait times and take corrective action for failure to comply. The CONTRACTOR shall conduct surveys and office visits to monitor compliance with appointment waiting time standards and shall report findings and corrective actions to TENNCARE in accordance with Section 2.30.7.2.
- 2.11.1.11 The CONTRACTOR shall use its best efforts to contract with providers to whom the CONTRACTOR routinely refers members.
- 2.11.1.12 TENNCARE reserves the right to direct the CONTRACTOR to terminate or modify any provider agreement when TENNCARE determines it to be in the best interest of the State.
- 2.11.1.13 To demonstrate sufficient accessibility and availability of covered services, the CONTRACTOR shall comply with all reporting requirements specified in Section 2.30.7.

2.11.2 Primary Care Providers (PCPs)

- 2.11.2.1 With the exception of members dually eligible for Medicare and TennCare, the CONTRACTOR shall ensure that each member has an assigned PCP, as defined in Section 1, who is responsible for coordinating the covered services provided to the member. For CHOICES members, the CONTRACTOR shall develop and implement protocols that address, at a minimum, the roles and responsibilities of the PCP and care coordinator and collaboration between a member's PCP and care coordinator.
- 2.11.2.2 The CONTRACTOR shall ensure that there are PCPs willing and able to provide the level of care and range of services necessary to meet the medical and behavioral health needs of its members, including those with chronic conditions. There shall be a sufficient number of PCPs who accept new TennCare members within the CONTRACTOR's service area so that the CONTRACTOR meets the access standards provided in Attachment III.
- 2.11.2.3 To the extent feasible and appropriate, the CONTRACTOR shall offer each member (other than members who are dually eligible for Medicare and TennCare) the opportunity to select a PCP.
- 2.11.2.4 The CONTRACTOR may, at its discretion, allow vulnerable populations (for example, persons with multiple disabilities, acute, or chronic conditions, as determined by the CONTRACTOR) to select their attending specialists as their PCP so long as the specialist is willing to perform all responsibilities of a PCP as defined in Section 1.

- 2.11.2.5 Children in State custody shall be assigned to a Best Practice Network Primary Care Provider as specified in Section 3 of this Agreement.
- 2.11.2.6 If a member who is not dually eligible for Medicare and TennCare fails or refuses to select a PCP from those offered within thirty (30) calendar days of enrollment, the CONTRACTOR shall assign a PCP. The CONTRACTOR may assign a PCP in less than thirty (30) calendar days if the CONTRACTOR provides the enrollee an opportunity to change PCPs upon receipt of notice of PCP assignment.
- 2.11.2.7 The CONTRACTOR shall establish policies and procedures to enable members reasonable opportunities to change PCPs. Such policies and procedures may not specify a length of time greater than twelve (12) months between PCP changes under normal circumstances. If the ability to change PCPs is limited, the CONTRACTOR shall include provisions for more frequent PCP changes with good cause. The policies and procedures shall include a definition of good cause as well as the procedures to request a change.
- 2.11.2.8 If a member requests assignment to a PCP located outside the distance/time requirements in Attachment III and the CONTRACTOR has PCPs available within the distance/time requirements who accept new members, it shall not be considered a violation of the access requirements for the CONTRACTOR to grant the member's request. However, in such cases the CONTRACTOR shall have no responsibility for providing transportation for the member to access care from this selected provider, and the CONTRACTOR shall notify the member in writing as to whether or not the CONTRACTOR will provide transportation for the member to seek care from the requested provider. In these cases, the CONTRACTOR shall allow the member to change assignment to a PCP within the distance/time requirements at any time if the member requests such a change.

2.11.3 Specialty Service Providers

2.11.3.1 Essential Hospital Services and Centers of Excellence

- 2.11.3.1.1 The CONTRACTOR shall demonstrate sufficient access to essential hospital services which means that, at a minimum, in each Grand Region served by the CONTRACTOR, the CONTRACTOR shall demonstrate a contractual arrangement with at least one (1) tertiary care center for each of the following:
 - 2.11.3.1.1.1 Neonatal services;
 - 2.11.3.1.1.2 Perinatal services;
 - 2.11.3.1.1.3 Pediatric services;
 - 2.11.3.1.1.4 Trauma services; and
 - 2.11.3.1.1.5 Burn services.
- 2.11.3.1.2 The CONTRACTOR shall demonstrate sufficient access to comprehensive care for people with HIV/AIDS which means that, at a minimum, in each Grand Region in

which the CONTRACTOR operates, the CONTRACTOR shall demonstrate a contractual arrangement with at least two (2) HIV/AIDS Centers of Excellence located within the CONTRACTOR's approved Grand Region(s). HIV/AIDS centers of Excellence are designated by the DOH.

2.11.3.1.3 The CONTRACTOR shall demonstrate a contractual arrangement with all Centers of Excellence for Behavioral Health located within the Grand Region(s) served by the CONTRACTOR.

2.11.3.1.4 The CONTRACTOR shall demonstrate a contractual arrangement with all Centers of Excellence for children in, or at risk of State custody, as identified by TennCare.

2.11.3.2 Physician Specialists

2.11.3.2.1 The CONTRACTOR shall establish and maintain a network of physician specialists that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical and behavioral health needs of its members (adults and children) without excessive travel requirements. This means that, at a minimum:

2.11.3.2.1.1 The CONTRACTOR has signed provider agreements with providers of the specialty types listed in Attachment IV who accept new TennCare enrollees and are available on at least a referral basis; and

2.11.3.2.1.2 The CONTRACTOR is in compliance with the access and availability requirements in Attachments III, IV, and V.

2.11.3.3 TENNCARE Monitoring

2.11.3.3.1 TENNCARE will monitor CONTRACTOR compliance with specialty network standards on an ongoing basis. TENNCARE will use data from the monthly *Provider Enrollment File* required in Section 2.30.7.1, to verify compliance with the specialty network requirements. TENNCARE will use these files to confirm the CONTRACTOR has a sufficient number and distribution of physician specialists and in conjunction with MCO enrollment data to calculate member to provider ratios. TENNCARE will also periodically phone providers listed on these reports to confirm that the provider is a contract provider as reported by the CONTRACTOR. TENNCARE shall also monitor appeals data for indications that problems exist with access to specialty providers.

2.11.3.3.2 TENNCARE will require a corrective action plan from the CONTRACTOR when:

2.11.3.3.2.1 Twenty-five percent (25%) or more of non-dual members do not have access to one or more of the physician specialties listed in Attachment IV within sixty (60) miles;

2.11.3.3.2.2 Any non-dual member does not have access to one or more of the physician specialties listed in Attachment IV within ninety (90) miles; or

2.11.3.3.2.3 The member to provider ratio exceeds that listed in Attachment IV.

- 2.11.3.3.3 TENNCARE will review all corrective action plans and determine, based on the actions proposed by the CONTRACTOR, appeals data, and the supply of specialty providers available to non-TennCare members, whether the corrective action plan will be accepted. Corrective action plans shall include, at a minimum, the following:
 - 2.11.3.3.3.1 The addition of contract providers to the provider network as documented on the provider enrollment file that resolves the specialty network deficiency;
 - 2.11.3.3.3.2 A list of providers with name, location, and expected date of provider agreement execution with whom the CONTRACTOR is currently negotiating a provider agreement and, if the provider becomes a contract provider would resolve the specialty network deficiency;
 - 2.11.3.3.3.3 For those deficiencies that are not resolved, a detailed account of attempts to secure an agreement with each provider that would resolve the deficiency. This shall include the provider name(s), address(es), date(s) contacted, and a detailed explanation as to why the CONTRACTOR is unable to secure an agreement, e.g., lack of provider willingness to participate in the TennCare program, provider prefers to limit access to practice, or rate requests are inconsistent with TennCare actuarial assumptions;
 - 2.11.3.3.3.4 A listing of non-contract providers, including name and location, who are being used to provide the deficient specialty provider services and the rates the CONTRACTOR is currently paying these non-contract providers;
 - 2.11.3.3.3.5 Affirmation that transportation will be provided for members to obtain services from providers who are willing to provide services to members but do not meet the specialty network standards;
 - 2.11.3.3.3.6 Documentation of how these arrangements are communicated to the member; and
 - 2.11.3.3.3.7 Documentation of how these arrangements are communicated to the PCPs.

2.11.4 **Special Conditions for Prenatal Care Providers**

- 2.11.4.1 The CONTRACTOR shall have a sufficient number of contract providers who accept members in accordance with TennCare access standards in Attachment III so that prenatal or other medically necessary covered services are not delayed or denied to pregnant women at any time, including during their presumptive eligibility period. Additionally, the CONTRACTOR shall make services available from non-contract providers, if necessary, to provide medically necessary covered services to a woman enrolled in the CONTRACTOR's MCO.
- 2.11.4.2 Regardless of whether prenatal care is provided by a PCP, physician extender or an obstetrician who is not the member's PCP, the access standards for PCP services shall apply when determining access to prenatal care except for cases of a first prenatal care appointment for women who are past their first trimester of pregnancy on the day they are determined to be eligible for TennCare. For women who are past their first trimester of pregnancy on the day they are determined to be eligible, a first prenatal care appointment shall occur within fifteen (15) calendar days of the day

they are determined to be eligible. Failure to do so shall be considered a material breach of the provider's provider agreement with the CONTRACTOR (see Sections 2.7.5.2 and 2.11.4).

2.11.5 Special Conditions for Behavioral Health Services

- 2.11.5.1 At the direction of the State, the CONTRACTOR shall divert new admissions to other inpatient facilities to ensure that the Regional Mental Health Institutes do not operate above their licensed capacity.
- 2.11.5.2 The CONTRACTOR shall identify, develop or enhance existing mental health and/or substance abuse inpatient and residential treatment capacity for adults and adolescents with a co-occurring mental health and substance abuse disorder.
- 2.11.5.3 The CONTRACTOR shall contract with specified crisis service teams for both adults and children as directed by TENNCARE unless the State approves the use of other crisis service providers.

2.11.6 Special Conditions for Long-Term Care Providers

In addition to the requirements in Section 2.11.1 of this Agreement and the access standards specified in Attachment III of this Agreement, the CONTRACTOR shall meet the following requirements for long-term care providers. Unless and until directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the requirements in this Section 2.11.6 applicable only to HCBS providers will not apply. If and when directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the CONTRACTOR shall, as directed by TENNCARE, implement all of the requirements in this Section 2.11.6.

- 2.11.6.1 The CONTRACTOR shall contract with all current nursing facilities (as defined in TCA 71-5-1412(b)) that meet all CMS certification requirements, for a minimum of three (3) years following the effective date of CHOICES implementation. Thereafter, the CONTRACTOR shall contract with a sufficient number of nursing facilities in order to have adequate capacity to meet the needs of CHOICES members for nursing facility services.
- 2.11.6.2 For community-based residential alternatives (covered for members in CHOICES Group 2), the CONTRACTOR shall demonstrate good faith efforts to develop the capacity to have a travel distance of no more than sixty (60) miles between a member's community-based residential alternative placement and the member's residence before entering the facility.
- 2.11.6.3 At a minimum, the CONTRACTOR shall contract with at least two (2) providers for each HCBS, other than community-based residential alternatives, to cover each county in each Grand Region covered under this Agreement. For HCBS provided in a member's place of residence, the provider does not need to be located in the county of the member's residence but must be willing and able to serve residents of that county. For adult day care, the provider does not have to be located in the county of the member's residence but must meet the access standards for adult day care specified in Attachment III.

- 2.11.6.4 The CONTRACTOR shall have adequate HCBS provider capacity to meet the needs of each and every member in CHOICES Group 2 and 3 and to provide authorized HCBS within the timeframe prescribed in Sections 2.9.2, 2.9.3, and 2.9.6 of this Agreement. This includes initiating HCBS in the member's plan of care within the timeframes specified in this Agreement and continuing services in accordance with the member's plan of care, including the amount, frequency, duration and scope of each service in accordance with the member's service schedule.
- 2.11.6.5 Following the first quarter of CHOICES implementation or as otherwise specified by TENNCARE, TENNCARE will review all relevant reports submitted by the CONTRACTOR, including but not limited to reports that address provider network, service initiation, missed visits, and service utilization. TENNCARE will use the data provided in these reports to establish long-term care provider capacity requirements and develop performance standards, benchmarks and associated liquidated damages for failure to meet the specified performance standards and benchmarks. TENNCARE will notify the CONTRACTOR of the performance standards, benchmarks, and liquidated damages including the timeframe for imposing liquidated damages.
- 2.11.6.6 The CONTRACTOR shall develop and maintain a network development plan to ensure the adequacy and sufficiency of its provider network. The network development plan shall be submitted to TENNCARE annually, monitored by TENNCARE per the requirements in Section 2.25 of the Agreement, and include the following minimum elements:
 - 2.11.6.6.1 Summary of nursing facility provider network, by county.
 - 2.11.6.6.2 Summary of HCBS provider network, including community-based residential alternatives, by service and county.
 - 2.11.6.6.3 Demonstration of and monitoring activities to ensure that access standards for long-term care services are met, including requirements in Attachment III and in this Section 2.11.6.
 - 2.11.6.6.4 Demonstration of the CONTRACTOR's ongoing activities to track and trend every time a member does not receive initial or ongoing long-term care services in accordance with the requirements of this Agreement due to inadequate provider capacity, identify systemic issues, and implement remediation and quality improvement (QI) activities. This shall include a summary of provider network capacity issues by service and county, the CONTRACTOR's remediation and QI activities and the targeted and actual completion dates for those activities.
 - 2.11.6.6.5 HCBS network deficiencies (in addition to those specified in Section 2.11.6.6.4 above) by service and by county and interventions to address the deficiencies.
 - 2.11.6.6.6 Demonstration of the CONTRACTOR's efforts to develop and enhance existing community-based residential alternatives (including adult care homes) capacity for elders and/or adults with physical disabilities. The CONTRACTOR shall specify related activities, including provider recruitment activities, and provide a status update on capacity building.

- 2.11.6.6.7 Where there are deficiencies or as otherwise applicable, annual target increase in HCBS providers by service and county.
- 2.11.6.6.8 Ongoing activities for HCBS provider development and expansion taking into consideration identified provider capacity, network deficiencies, and service delivery issues and future needs relating to growth in membership and long-term needs.
- 2.11.6.7 The CONTRACTOR shall assist in developing an adequate qualified workforce for covered long-term care services. The CONTRACTOR shall develop and implement strategies to increase the pool of available qualified direct care staff and to improve retention of qualified direct care staff. The strategies may include, for example, establishing partnerships with local colleges and technical training schools; establishing partnerships with professional and trade associations and pursuing untapped labor pools such as elders. The CONTRACTOR shall report annually to TENNCARE on the status of its qualified workforce development strategies (see Section 2.30.7.8). Unless and until directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the CONTRACTOR shall assist in developing an adequate qualified workforce for nursing facility services.

2.11.7 Safety Net Providers

2.11.7.1 Federally Qualified Health Centers (FQHCs)

2.11.7.1.1 The CONTRACTOR is encouraged to contract with FQHCs and other safety net providers (e.g., rural health clinics) in the CONTRACTOR's service area to the extent possible and practical. Where FQHCs are not utilized, the CONTRACTOR shall demonstrate to DHHS, the Tennessee DHS and TENNCARE that both adequate capacity and an appropriate range of services for vulnerable populations exist to serve the expected enrollment in the CONTRACTOR's service area without contracting with FQHCs.

2.11.7.1.2 FQHC reporting information shall be submitted to TENNCARE as described in Section 2.30.7.9 of this Agreement.

2.11.7.2 Community Mental Health Agencies (CMHAs)

The CONTRACTOR is encouraged to contract with CMHAs and other behavioral health safety net providers in the CONTRACTOR's service area to the extent possible and practical. Where CMHAs are not utilized, the CONTRACTOR shall demonstrate that both adequate capacity and an appropriate range of services for all populations, but in particular SPMI/SED populations, exist to serve the expected enrollment in the CONTRACTOR's service area without contracting with CMHAs.

2.11.7.3 Local Health Departments

The CONTRACTOR shall contract with each local health department in the Grand Region(s) served by the CONTRACTOR for the provision of TENNderCare screening services until such time as the CONTRACTOR achieves an adjusted periodic screening percentage of eighty percent (80%) or greater. Payment to local health departments shall be in accordance with Section 2.13.8.

2.11.8 **Credentialing and Other Certification**

2.11.8.1 Credentialing of Contract Providers

2.11.8.1.1 Except as provided in Sections 2.11.8.3 and 2.11.8.4 below, the CONTRACTOR shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.

2.11.8.1.2 The CONTRACTOR shall completely process credentialing applications from all types of providers (physical health, behavioral health and long-term care providers) within thirty (30) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement. Completely process shall mean that the CONTRACTOR shall review, approve and load approved applicants to its provider files in its claims processing system or deny the application and assure that the provider is not used by the CONTRACTOR.

2.11.8.2 Credentialing of Non-Contract Providers

2.11.8.2.1 The CONTRACTOR shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers with whom it does not contract but with whom it has an independent relationship. An independent relationship exists when the CONTRACTOR selects and directs its members to see a specific provider or group of providers.

2.11.8.2.2 The CONTRACTOR shall completely process credentialing applications within thirty (30) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed contract/agreement if applicable. Completely process shall mean that the CONTRACTOR shall review, approve and load approved applicants to its provider files in its claims processing system or deny the application and assure that the provider is not used by the CONTRACTOR.

2.11.8.3 Credentialing of Behavioral Health Entities

2.11.8.3.1 The CONTRACTOR shall ensure each behavioral health provider's service delivery site meets all applicable requirements of law and has the necessary and current license/certification/accreditation/designation approval per state requirements.

2.11.8.3.2 When individuals providing behavioral health treatment services are not required to be licensed or certified, it is the responsibility of the CONTRACTOR to ensure, based on applicable state licensure rules and/or programs standards, that they are appropriately educated, trained, qualified, and competent to perform their job responsibilities.

2.11.8.4 Credentialing of Long-Term Care Providers

2.11.8.4.1 The CONTRACTOR shall develop and implement a process for credentialing and recredentialing long-term care providers. The CONTRACTOR's process shall, as applicable, meet the minimum NCQA requirements as specified in the NCQA Standards and Guidelines for the Accreditation of MCOs. In addition, the CONTRACTOR shall ensure that all long-term care providers, including those credentialed/recruited in accordance with NCQA Standards and Guidelines for the Accreditation of MCOs, meet applicable State requirements, as specified by TENNCARE.

2.11.8.4.2 To the extent possible the CONTRACTOR shall develop a streamlined credentialing process for nursing facility and HCBS providers enrolled in TennCare prior to the effective date of CHOICES implementation in each Grand Region, and, to the extent permitted under NCQA Standards and Guidelines for the Accreditation of MCOs, the CONTRACTOR shall use credentialing requirements that are consistent with the State provider qualifications in place for long-term care providers at CHOICES implementation.

2.11.8.4.3 Unless and until directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the requirements in Section 2.11.8.4 will apply only to nursing facility providers. If and when directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the CONTRACTOR shall, as directed by TENNCARE, implement all of the requirements in Section 2.11.8.4.

2.11.8.5 Compliance with the Clinical Laboratory Improvement Amendments (CLIA) of 1988

The CONTRACTOR shall require that all laboratory testing sites providing services under this Agreement have either a current CLIA certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver will provide only the types of tests permitted under the terms of their waiver. Laboratories with certificate of registration may perform a full range of laboratory tests. The CONTRACTOR shall comply with the provisions of CLIA 1988.

2.11.8.6 Weight Watchers Centers or Other Weight Management Program

The CONTRACTOR is not required to credential Weight Watchers centers(s) or another weight management program used as a cost effective alternative service pursuant to Section 2.8.8 of this Agreement.

2.11.9 Network Notice Requirements

2.11.9.1 Member Notification

All member notices required shall be written using the appropriate notice template provided by TENNCARE and shall include all notice content requirements specified in applicable state and federal law, TennCare rules and regulations, and all court orders and consent decrees governing notice and appeal procedures, as they become effective.

2.11.9.1.1 *Change in PCP*

The CONTRACTOR shall immediately provide written notice to a member when the CONTRACTOR changes the member's PCP. The notice shall be issued in advance of the PCP change when possible or as soon as the CONTRACTOR becomes aware of the circumstances necessitating a PCP change.

2.11.9.1.2 *PCP Termination*

If a PCP ceases participation in the CONTRACTOR's MCO, the CONTRACTOR shall provide written notice as soon as possible, but no less than thirty (30) calendar days prior to the effective date of the termination and no more than fifteen (15) calendar days after receipt or issuance of the termination notice, to each member who has chosen or been assigned to that provider as their PCP. The requirement to provide notice thirty (30) calendar days prior to the effective date of termination shall be waived in instances where a provider becomes physically unable to care for members due to illness, a provider dies, the provider fails to provide thirty (30) calendar days advance notice to the CONTRACTOR, the provider moves from the service area and fails to notify the CONTRACTOR or a provider fails credentialing, and instead shall be made immediately upon the CONTRACTOR becoming aware of the circumstances.

2.11.9.1.3 *Physical Health or Behavioral Health Providers Providing Ongoing Treatment Termination*

If a member is in a prior authorized ongoing course of treatment with any other contract provider who becomes unavailable to continue to provide services to such member and the CONTRACTOR is aware of such ongoing course of treatment, the CONTRACTOR shall provide written notice to each member as soon as possible but no less than thirty (30) calendar days prior to the effective date of the termination and no more than fifteen (15) calendar days after receipt or issuance of the termination notice. The requirement to provide notice thirty (30) calendar days prior to the effective date of termination shall be waived in instances where a provider becomes physically unable to care for members due to illness, a provider dies, the provider fails to provide thirty (30) calendar days advance notice to the CONTRACTOR, the provider moves from the service area and fails to notify the CONTRACTOR or a provider fails credentialing, and instead shall be made immediately upon the CONTRACTOR becoming aware of the circumstances.

2.11.9.1.4 *Non-PCP Provider Termination*

If a non-PCP provider, including but not limited to a specialist or hospital, ceases participation in the CONTRACTOR's MCO, the CONTRACTOR shall provide written notice to members who have been seen and/or treated by the non-PCP provider within the last six (6) months. Notice shall be issued no less than thirty (30) days prior to the effective date of the termination of the non-PCP provider when possible or immediately upon the CONTRACTOR becoming aware of the termination.

2.11.9.1.5 *Long-Term Care Provider Termination*

If a long-term care provider ceases participation in the CONTRACTOR's MCO the CONTRACTOR shall provide written notice as soon as possible, but no less than thirty (30) calendar days prior to the effective date of the termination and no more than fifteen (15) calendar days after receipt or issuance of the termination notice, to each member who has chosen or is authorized to receive long-term care services from that provider. Notices regarding termination by a nursing facility shall comply with state and federal requirements. The requirement in this Section 2.11.9.1.5 to provide notice thirty (30) calendar days prior to the effective date of termination shall be waived in instances where a provider becomes physically unable to care for members due to illness, a provider dies, the provider fails to provide thirty (30) calendar days advance notice to the CONTRACTOR, the provider moves from the service area and fails to notify the CONTRACTOR or a provider fails credentialing, and instead shall be made immediately upon the CONTRACTOR becoming aware of the circumstances. See Section 2.9.4 of this Agreement regarding requirements for transitioning from a terminating provider to a new provider.

2.11.9.1.6 *Network Deficiency*

Upon notification from TENNCARE that a corrective action plan designed to remedy a network deficiency has not been accepted, the CONTRACTOR shall immediately provide written notice to members living in the affected area of a provider shortage in the CONTRACTOR's network.

2.11.9.2 TENNCARE Notification

2.11.9.2.1 *Subcontractor Termination*

When a subcontract that relates to the provision of services to members or claims processing is being terminated between the CONTRACTOR and a subcontractor, the CONTRACTOR shall give at least thirty (30) calendar days prior written notice of the termination to TENNCARE and TDCI. Said notices shall include, at a minimum: a CONTRACTOR's intent to change to a new subcontractor for the provision of said services; an effective date for termination and/or change; and any other pertinent information that may be needed to access services. In addition to prior written notice, the CONTRACTOR shall also provide a transition plan to TENNCARE within fifteen (15) calendar days, which shall include, at a minimum, information regarding how prior authorization requests will be handled during and after the transition and how continuity of care will be maintained for the members.

2.11.9.2.2 *Hospital Termination*

Termination of the CONTRACTOR's provider agreement with any hospital, whether or not the termination is initiated by the hospital or by the CONTRACTOR, shall be reported by the CONTRACTOR in writing to the TENNCARE no less than thirty (30) calendar days prior to the effective date of the termination.

2.11.9.2.3 *Other Provider Terminations*

2.11.9.2.3.1 The CONTRACTOR shall notify TENNCARE of any provider termination and shall submit an Excel spreadsheet that includes the provider's name, TennCare provider identification number, NPI number, and the number of members affected within five (5) business days of the provider's termination. If the termination was initiated by the provider, the notice to TENNCARE shall include a copy of the provider's notification to the CONTRACTOR. The CONTRACTOR shall maintain documentation of all information, including a copy of the actual member notice(s), on-site. Upon request, the CONTRACTOR shall provide TENNCARE a copy of the following: one or more of the actual member notices mailed, an electronic listing in Excel identifying each member to whom a notice was sent, a transition plan for the members affected, and documentation from the CONTRACTOR's mail room or outside vendor indicating the quantity and date member notices were mailed as proof of compliance with the member notification requirements.

2.11.9.2.3.2 If termination of the CONTRACTOR's provider agreement with any PCP or physician group or clinic or long-term care provider, whether or not the termination is initiated by the provider or by the CONTRACTOR, places the CONTRACTOR out of compliance with Section 2.11 and/or Attachments III, IV and V, such termination shall be reported by the CONTRACTOR in writing to TENNCARE, in the standard format provided by TENNCARE to demonstrate compliance with provider network and access requirements, within five (5) business days of the date that the agreement has been terminated.

14. Section 2.12 shall be amended by deleting Section 2.12 in its entirety and replacing it with the following and renumbering all references thereto:

2.12 PROVIDER AGREEMENTS

2.12.1 Provider agreements, as defined in Section 1 of this Agreement, shall be administered in accordance with this Agreement and shall contain or incorporate by reference to the provider handbook all of the items listed in this Section 2.12. Any requirements revised or added to Section 2.12 as part of amendment #22 may, for non-long-term care providers, be incorporated by reference to the provider handbook and included, as appropriate, in the next amendment to provider agreements.

2.12.2 All template provider agreements and revisions thereto must be approved in writing in advance by TDCI in accordance with statutes regarding the approval of a certificate of authority (COA) and any material modifications thereof.

2.12.3 The CONTRACTOR shall revise provider agreements as directed by TENNCARE.

2.12.4 All single case agreements shall be reported to TENNCARE in accordance with Section 2.30.8; however, prior approval will not be required unless TENNCARE determines, upon review of said reports, that it appears single case agreements are being used to circumvent the provider agreement review and approval process.

2.12.5 No provider agreement terminates or reduces the legal responsibility of the CONTRACTOR to TENNCARE to ensure that all activities under this Agreement

are carried out. It shall be the responsibility of the CONTRACTOR to provide all necessary training and information to providers to ensure satisfaction of all CONTRACTOR responsibilities as specified in this Agreement.

- 2.12.6 The CONTRACTOR shall not execute provider agreements with providers who have been excluded from participation in the Medicare, Medicaid, and/or SCHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with the TennCare program.
- 2.12.7 The CONTRACTOR shall not include covenant-not-to-compete requirements in its provider agreements. The CONTRACTOR shall not execute provider agreements that require that a provider not provide services for any other TennCare MCO.
- 2.12.8 The CONTRACTOR shall not execute provider agreements that contain compensation terms that discourage providers from serving any specific eligibility category or population covered by this Agreement.
- 2.12.9 All provider agreements executed by the CONTRACTOR, and all provider agreements executed by subcontracting entities or organizations, shall, except as otherwise provided in Section 2.12.13, at a minimum, meet the following requirements:
 - 2.12.9.1 Be in writing. All new provider agreements and existing provider agreements as they are renewed, shall include a signature page which contains CONTRACTOR and provider names which are typed or legibly written, provider company with titles, and dated signatures of all appropriate parties;
 - 2.12.9.2 Specify the effective dates of the provider agreement;
 - 2.12.9.3 Specify that the provider agreement and its attachments contain all the terms and conditions agreed upon by the parties;
 - 2.12.9.4 Assure that the provider shall not enter into any subsequent agreements or subcontracts for any of the work contemplated under the provider agreement without the prior written approval of the CONTRACTOR;
 - 2.12.9.5 Identify the population covered by the provider agreement;
 - 2.12.9.6 Specify that the provider may not refuse to provide covered medically necessary or covered preventive services to a child under the age of twenty-one (21) or a TennCare Medicaid patient under this Agreement for non-medical reasons. However, the provider shall not be required to accept or continue treatment of a patient with whom the provider feels he/she cannot establish and/or maintain a professional relationship;
 - 2.12.9.7 Specify the functions and/or services to be provided by the provider and assure that the functions and/or services to be provided are within the scope of his/her professional/technical practice;

- 2.12.9.8 Specify the amount, duration and scope of services to be provided by the provider and inform the provider of TennCare non-covered services as described in Section 2.10 of this Agreement and the TennCare rules and regulations;
- 2.12.9.9 Provide that emergency services be rendered without the requirement of prior authorization of any kind;
- 2.12.9.10 Require compliance with applicable access requirements, including but not limited to appointment and wait times as referenced in Section 2.11 of the CONTRACTOR's Agreement with TENNCARE;
- 2.12.9.11 Specify that unreasonable delay in providing care to a pregnant member seeking prenatal care shall be considered a material breach of the provider's agreement with the CONTRACTOR and include the definition of unreasonable delay as described in Section 2.7.5.2.3 of this Agreement;
- 2.12.9.12 If the provider performs laboratory services, require the provider to meet all applicable requirements of the Clinical Laboratory Improvement Amendments (CLIA) of 1988;
- 2.12.9.13 Require the provider to have and maintain documentation necessary to demonstrate that covered services were provided in compliance with state and federal requirements;
- 2.12.9.14 Require that an adequate record system be maintained and that all records be maintained for five (5) years from the close of the provider agreement (behavioral health records shall be maintained at the provider level for ten (10) years after the termination of the provider agreement pursuant to TCA 33-3-101) or retained until all evaluations, audits, reviews or investigations or prosecutions are completed for recording enrollee services, servicing providers, charges, dates and all other commonly accepted information elements for services rendered to enrollees pursuant to the provider agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the provider agreement and administrative, civil or criminal investigations and prosecutions);
- 2.12.9.15 Include a statement that as a condition of participation in TennCare, enrollees shall give TENNCARE, the Office of the Comptroller of the Treasury, and any health oversight agency, such as OIG, TBI MFCU, DHHS Office of Inspector General (DHHS OIG), and DOJ, and any other authorized state or federal agency, access to their records. Said records shall be made available and furnished immediately upon request by the provider for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring as well as for administrative, civil and criminal investigations or prosecutions upon the request of an authorized representative of the CONTRACTOR, TENNCARE or authorized federal, state and Office of the Comptroller of the Treasury personnel, including, but not limited to, the OIG, the TBI MFCU, the DHHS OIG and the DOJ;
- 2.12.9.16 Include medical records requirements found in Section 2.24.6 of this Agreement;

- 2.12.9.17 Contain the language described in Section 2.25.6 of this Agreement regarding Audit Requirements and Section 2.25.5 of this Agreement regarding Availability of Records;
- 2.12.9.18 Provide that TENNCARE, DHHS OIG, Office of the Comptroller of the Treasury, OIG, TBI MFCU, and DOJ, as well as any authorized state or federal agency or entity shall have the right to evaluate through inspection, evaluation, review or request, whether announced or unannounced, or other means any records pertinent to this Agreement including, but not limited to medical records, billing records, financial records, and/or any records related to services rendered, quality, appropriateness and timeliness of services and/or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution and such evaluation, inspection, review or request, and when performed or requested, shall be performed with the immediate cooperation of the provider. Upon request, the provider shall assist in such reviews including the provision of complete copies of medical records. Include a statement that HIPAA does not bar disclosure of protected health information (PHI) to health oversight agencies, including, but not limited to, OIG, TBI MFCU, DHHS OIG and DOJ. Provide that any authorized state or federal agency or entity, including, but not limited to TENNCARE, OIG, TBI MFCU, DHHS OIG, DOJ, Office of the Comptroller of the Treasury, may use these records and information for administrative, civil or criminal investigations and prosecutions;
- 2.12.9.19 Provide for monitoring, whether announced or unannounced, of services rendered to members;
- 2.12.9.20 Provide for the participation and cooperation in any internal and external QM/QI, monitoring, utilization review, peer review and/or appeal procedures established by the CONTRACTOR and/or TENNCARE;
- 2.12.9.21 Specify CONTRACTOR's responsibilities under this Agreement and its agreement with the provider, including but not limited to, provision of a copy of the member handbook and provider handbook whether via web site or otherwise and requirement that the CONTRACTOR notice a provider of denied authorizations;
- 2.12.9.22 Specify that the CONTRACTOR shall monitor the quality of services delivered under the provider agreement and initiate corrective action where necessary to improve quality of care, in accordance with that level of medical, behavioral health, or long-term care which is recognized as acceptable professional practice in the respective community in which the provider practices and/or the standards established by TENNCARE;
- 2.12.9.23 Require that the provider comply with corrective action plans initiated by the CONTRACTOR;
- 2.12.9.24 Provide for the timely submission of all reports and clinical information required by the CONTRACTOR;
- 2.12.9.25 Provide the name and address of the official payee to whom payment shall be made;

- 2.12.9.26 Make full disclosure of the method and amount of compensation or other consideration to be received from the CONTRACTOR. However, the agreement shall not include rate methodology that provides for an automatic increase in rates;
- 2.12.9.27 Specify that the CONTRACTOR shall only pay providers for services (1) provided in accordance with the requirements of this Agreement, the CONTRACTOR's policies and procedures implementing this Agreement, and state and federal law and (2) provided to TennCare enrollees who are enrolled with the CONTRACTOR; and specify that the provider is responsible for (1) ensuring that any applicable authorization requirements are met and (2) verifying that a person is eligible for TennCare on the date of service;
- 2.12.9.28 Provide for prompt submission of information needed to make payment. Specify that a provider shall have one hundred twenty (120) calendar days from the date of rendering a covered service to file a claim with the CONTRACTOR except in situations regarding coordination of benefits or subrogation in which case the provider is pursuing payment from a third party or if an enrollee is enrolled in the MCO with a retroactive eligibility date. In situations of third party benefits, the maximum time frames for filing a claim shall begin on the date that the third party documented resolution of the claim. In situations of enrollment in the CONTRACTOR's MCO with a retroactive eligibility date, the time frames for filing a claim shall begin on the date that the CONTRACTOR receives notification from TENNCARE of the enrollee's eligibility/enrollment;
- 2.12.9.29 Provide for payment to the provider upon receipt of a clean claim properly submitted by the provider within the required time frames as specified in TCA 56-32-126 and Section 2.22.4 of this Agreement;
- 2.12.9.30 Specify the provider shall accept payment or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payer) plus the amount of any applicable TennCare cost sharing responsibilities, as payment in full for covered services provided and shall not solicit or accept any surety or guarantee of payment from the enrollee in excess of the amount of applicable TennCare cost sharing responsibilities. Enrollee shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the enrollee being served;
- 2.12.9.31 Specify that in the event that TENNCARE deems the CONTRACTOR unable to timely process and reimburse claims and requires the CONTRACTOR to submit provider claims for reimbursement to an alternate claims processor to ensure timely reimbursement, the provider shall agree to accept reimbursement at the CONTRACTOR's contracted reimbursement rate or the rate established by TENNCARE, whichever is greater;
- 2.12.9.32 Specify the provider's responsibilities and prohibited activities regarding cost sharing as provided in Section 2.6.7 of this Agreement;
- 2.12.9.33 Specify the provider's responsibilities regarding third party liability (TPL), including the provider's obligation to identify third party liability coverage, including Medicare and long-term care insurance as applicable, and, except as otherwise provided in the

CONTRACTOR's Agreement with TENNCARE, to seek such third party liability payment before submitting claims to the CONTRACTOR;

- 2.12.9.34 For those agreements where the provider is compensated via a capitation arrangement, language which requires:
 - 2.12.9.34.1 That if a provider becomes aware for any reason that he or she is not entitled to a capitation payment for a particular enrollee (a patient dies, for example), the provider shall immediately notify both the CONTRACTOR and TENNCARE by certified mail, return receipt requested; and
 - 2.12.9.34.2 The provider shall submit utilization or encounter data as specified by the CONTRACTOR so as to ensure the CONTRACTOR's ability to submit encounter data to TENNCARE that meets the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims;
- 2.12.9.35 Require the provider to comply with fraud and abuse requirements described in Section 2.20 of this Agreement;
- 2.12.9.36 Require the provider to report suspected abuse, neglect, and exploitation of adults in accordance with TCA 71-6-103 and to report suspected brutality, abuse, or neglect of children in accordance with TCA 37-1-403 and TCA 37-1-605;
- 2.12.9.37 Require that, for CHOICES members, the provider facilitate notification of the member's care coordinator by notifying the CONTRACTOR, in accordance with the CONTRACTOR's processes, as expeditiously as warranted by the member's circumstances, of any known significant changes in the member's condition or care, hospitalizations, or recommendations for additional services;
- 2.12.9.38 Require hospitals, including psychiatric hospitals, to cooperate with the CONTRACTOR in developing and implementing protocols as part of the CONTRACTOR's nursing facility diversion plan (see Section 2.9.6.7), which shall include, at a minimum, the hospital's obligation to promptly notify the CONTRACTOR upon admission of an eligible member regardless of payor source for the hospitalization; how the hospital will identify members who may need home health, private duty nursing, nursing facility, or HCBS upon discharge, and how the hospital will engage the CONTRACTOR in the discharge planning process to ensure that members receive the most appropriate and cost-effective medically necessary services upon discharge;
- 2.12.9.39 Require the provider to conduct background checks in accordance with state law and TennCare policy;
- 2.12.9.40 As a condition of reimbursement for global procedures codes for obstetric care, the provider shall submit utilization or encounter data as specified by the CONTRACTOR in a timely manner to support the individual services provided;
- 2.12.9.41 Except as otherwise specified in Sections 2.12.11 or 2.12.12, require the provider to secure all necessary liability and malpractice insurance coverage as is necessary to adequately protect the CONTRACTOR's members and the CONTRACTOR under the provider agreement. The provider shall maintain such insurance coverage at all

times during the provider agreement and upon execution of the provider agreement furnish the CONTRACTOR with written verification of the existence of such coverage;

- 2.12.9.42 Specify both the CONTRACTOR and the provider agree to recognize and abide by all state and federal laws, regulations and guidelines applicable to the CONTRACTOR and the provider. Provide that the agreement incorporates by reference all applicable federal law and state laws, TennCare rules and regulations, consent decrees or court orders, and revisions of such laws, regulations, consent decrees or court orders shall automatically be incorporated into the provider agreement, as they become effective;
- 2.12.9.43 Specify procedures and criteria for any alterations, variations, modifications, waivers, extension of the provider agreement termination date, or early termination of the agreement and specify the terms of such change. If provision does not require amendments be valid only when reduced to writing, duly signed and attached to the original of the provider agreement, then the terms shall include provisions allowing at least thirty (30) calendar days to give notice of rejection and requiring that receipt of notification of amendments be documented (e.g., certified mail, facsimile, hand-delivered receipt, etc);
- 2.12.9.44 Include provisions that allow the CONTRACTOR to suspend, deny, refuse to renew or terminate any provider agreement in accordance with the terms of the CONTRACTOR's Agreement with TENNCARE (see Section 5.4) and applicable law and regulation;
- 2.12.9.45 Specify that TENNCARE reserves the right to direct the CONTRACTOR to terminate or modify the provider agreement when TENNCARE determines it to be in the best interest of the State;
- 2.12.9.46 Specify that both parties recognize that in the event of termination of this Agreement between the CONTRACTOR and TENNCARE for any of the reasons described in Section 5.4 of this Agreement, the provider shall immediately make available, to TENNCARE, or its designated representative, in a usable form, any or all records, whether medical or financial, related to the provider's activities undertaken pursuant to the CONTRACTOR/provider agreement. The provision of such records shall be at no expense to TENNCARE;
- 2.12.9.47 Specify that the TennCare Provider Independent Review of Disputed Claims process shall be available to providers to resolve claims denied in whole or in part by the CONTRACTOR as provided at TCA 56-32-126(b);
- 2.12.9.48 Include a Conflict of Interest clause as stated in Section 5.19 of this Agreement, Gratuities clause as stated in Section 5.23 of this Agreement, and Lobbying clause as stated in Section 5.24 of this Agreement between the CONTRACTOR and TENNCARE;
- 2.12.9.49 Specify that at all times during the term of the agreement, the provider shall indemnify and hold TENNCARE harmless from all claims, losses, or suits relating to activities undertaken pursuant to the Agreement between TENNCARE and the CONTRACTOR. This indemnification may be accomplished by incorporating

Section 5.31 of the TENNCARE/CONTRACTOR Agreement in its entirety in the provider agreement or by use of other language developed by the CONTRACTOR and approved in writing by TENNCARE;

- 2.12.9.50 Require safeguarding of information about enrollees according to applicable state and federal laws and regulations and as described in Sections 2.27 and 5.33 of this Agreement;
- 2.12.9.51 Specify provider actions to improve patient safety and quality;
- 2.12.9.52 Provide general and targeted education to providers regarding emergency appeals, including when an emergency appeal is appropriate, and procedures for providing written certification thereof, and specify that the provider shall comply with the appeal process, including but not limited to the following:
 - 2.12.9.52.1 Assist an enrollee by providing appeal forms and contact information including the appropriate address, telephone number and/or fax number for submitting appeals for state level review; and
 - 2.12.9.52.2 Require in advance, that providers seek prior authorization, when they feel they cannot order a drug on the TennCare PDL as well as taking the initiative to seek prior authorization or change or cancel the prescription when contacted by an enrollee or pharmacy regarding denial of a pharmacy service due to system edits (e.g., therapeutic duplication, etc.).
- 2.12.9.53 Require the provider to coordinate with the TennCare PBM regarding authorization and payment for pharmacy services;
- 2.12.9.54 Specify any liquidated damages, sanctions or reductions in payment that the CONTRACTOR may assess on the provider for specific failures to comply with contractual and/or credentialing requirements. This shall include, but may not be limited to a provider's failure or refusal to respond to the CONTRACTOR's request for information, the request to provide medical records, credentialing information, etc.; at the CONTRACTOR's discretion or a directive by TENNCARE, the CONTRACTOR shall impose financial consequences against the provider as appropriate;
- 2.12.9.55 Require that the provider display notices of the enrollee's right to appeal adverse action affecting services in public areas of their facility(s) in accordance with TennCare rules and regulations, subsequent amendments, or any and all consent decrees and court orders. The CONTRACTOR shall ensure that providers have a correct and adequate supply of public notices;
- 2.12.9.56 Include language which informs providers of the package of benefits that TENNderCare offers and which requires providers to make treatment decisions based upon children's individual medical and behavioral health needs. TENNderCare requirements are contained in Section 2.7.6 of this Agreement. All provider agreements shall contain language that references the TENNderCare requirements in this Agreement between TENNCARE and the CONTRACTOR, and the provider agreement shall either physically incorporate these sections of the Agreement or

- include language to require that these sections be furnished to the provider upon request;
- 2.12.9.57 Include a provision which states that providers are not permitted to encourage or suggest, in any way, that TennCare children be placed into State custody in order to receive medical, behavioral, or long-term care services covered by TENNCARE;
 - 2.12.9.58 Require that providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees;
 - 2.12.9.59 Specify that the provider have written procedures for the provision of language interpretation and translation services for any enrollee who needs such services, including but not limited to, enrollees with Limited English Proficiency;
 - 2.12.9.60 Require the provider to comply and submit to the CONTRACTOR disclosure of information in accordance with the requirements specified in 42 CFR Part 455, Subpart B;
 - 2.12.9.61 Require providers to screen their employees and contractors initially and on an ongoing monthly basis to determine whether any of them has been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded. The provider shall be required to immediately report to the CONTRACTOR any exclusion information discovered. The provider shall be informed that civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to TennCare members; and
 - 2.12.9.62 Require that if any requirement in the provider agreement is determined by TENNCARE to conflict with the Agreement between TENNCARE and the CONTRACTOR, such requirement shall be null and void and all other provisions shall remain in full force and effect.
 - 2.12.10 No other terms or conditions agreed to by the CONTRACTOR and the provider shall negate or supersede the requirements listed in 2.12.9 above.
 - 2.12.11 The provider agreement with a nursing facility shall meet the minimum requirements specified in Section 2.12.9 above and shall also include, at a minimum, the following requirements:
 - 2.12.11.1 Require the nursing facility provider to promptly notify the CONTRACTOR, and/or State entity as directed by TENNCARE, of a member's admission or request for admission to the nursing facility regardless of payor source for the nursing facility stay, or when there is a change in a member's known circumstances and to notify the CONTRACTOR, and/or State entity as directed by TENNCARE, prior to a member's discharge;
 - 2.12.11.2 Require the nursing facility provider to provide written notice to TENNCARE and the CONTRACTOR in accordance with state and federal requirements before voluntarily terminating the agreement and to comply with all applicable state and federal requirements regarding voluntary termination;

- 2.12.11.3 Require the nursing facility provider to notify the CONTRACTOR immediately if the nursing facility is considering discharging a member and to consult with the member's care coordinator to intervene in resolving issues if possible and, if not, to prepare and implement a discharge and/or transition plan as appropriate;
- 2.12.11.4 Require the nursing facility to notify the member and/or the member's representative (if applicable) in writing prior to discharge in accordance with state and federal requirements;
- 2.12.11.5 Specify the provider shall accept payment or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the member's third party payer) plus the amount of any applicable patient liability, as payment in full for services provided and shall not solicit or accept any surety or guarantee of payment from the member in excess of the amount of applicable patient liability responsibilities. Member shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the member being served;
- 2.12.11.6 Specify the nursing facility provider's responsibilities regarding patient liability (see Sections 2.6.7 and 2.21.5 of this Agreement), which shall include but not be limited to collecting the applicable patient liability amounts from CHOICES Group 1 members, notifying the member's care coordinator if there is an issue with collecting a member's patient liability, and making good faith efforts to collect payment;
- 2.12.11.7 Specify the role of the nursing facility provider regarding timely certification and recertification (as applicable) of the member's level of care eligibility for Level I and/or Level II nursing facility care and require the nursing facility provider to cooperate fully with the CONTRACTOR in the completion and submission of the level of care assessment;
- 2.12.11.8 Require the nursing facility to notify the CONTRACTOR of any change in a member's medical or functional condition that could impact the member's level of care eligibility for the currently authorized level of nursing facility services;
- 2.12.11.9 Require the nursing facility provider to comply with state and federal laws and regulations applicable to nursing facilities as well as any applicable federal court orders, including but not limited to those that govern admission, transfer, and discharge policies;
- 2.12.11.10 Require the nursing facility to comply with federal Preadmission Screening and Resident Review (PASRR) requirements applicable to all nursing facility residents, regardless of payor source, including that a level I screening be completed prior to admission, a level II evaluation be completed prior to admission when indicated by the level I screening, and a review be completed based upon a significant physical or mental change in the resident's condition that might impact the member's need for or benefit from specialized services;
- 2.12.11.11 Require the nursing facility to cooperate with the CONTRACTOR in developing and implementing protocols as part of the CONTRACTOR's nursing facility diversion and transition plans (see Section 2.9.6.7), which shall, include, at a minimum, the

nursing facility's obligation to promptly notify the CONTRACTOR upon admission or request for admission of an eligible member regardless of payor source for the nursing facility stay; how the nursing facility will assist the CONTRACTOR in identifying residents who may want to transition from nursing facility services to home and community-based care; the nursing facility's obligation to promptly notify the CONTRACTOR regarding all such identified members; and how the nursing facility will work with the CONTRACTOR in assessing the member's transition potential and needs, and in developing and implementing a transition plan, as applicable;

- 2.12.11.12 Require the nursing facility provider to coordinate with the CONTRACTOR in complying with the requirements in 42 CFR 483.75 regarding written transfer agreements and shall use contract providers when transfer is medically appropriate, except as authorized by the CONTRACTOR or for emergency services;
- 2.12.11.13 Require the nursing facility provider to have on file a system designed and utilized to ensure the integrity of the member's personal financial resources. This system shall be designed in accordance with the regulations and guidelines set out by the Comptroller of the Treasury and the applicable federal regulations;
- 2.12.11.14 Require the nursing facility provider to immediately notify the CONTRACTOR of any change in its license to operate as issued by the Tennessee Department of Health as well as any deficiencies cited during the federal certification process;
- 2.12.11.15 Provide that if the nursing facility provider is involuntarily decertified by the Tennessee Department of Health or the Centers for Medicare and Medicaid Services, the provider agreement will automatically be terminated in accordance with federal requirements;
- 2.12.11.16 For a minimum of three (3) years following the effective date of CHOICES implementation (see Section 2.11.6.1 of this Agreement and TCA 71-5-1412(b)), shall not require the nursing facility provider to have liability insurance in excess of TENNCARE requirements in effect prior to the implementation of CHOICES; and
- 2.12.11.17 Include language requiring that the provider agreement shall be assignable from the CONTRACTOR to the State, or its designee, at the State's discretion upon written notice to the CONTRACTOR and the affected nursing facility provider. Further, the provider agreement shall include language by which the nursing facility provider agrees to be bound by any such assignment, and that the State, or its designee, shall not be responsible for past obligations of the CONTRACTOR.
- 2.12.12 The provider agreement with a HCBS provider shall meet the minimum requirements specified in Section 2.12.9 above and shall also include, at a minimum, the following requirements:
 - 2.12.12.1 Require the HCBS provider to provide at least thirty (30) days advance notice to the CONTRACTOR when the provider is no longer willing or able to provide services to a member, including the reason for the decision, and to cooperate with the member's care coordinator to facilitate a seamless transition to alternate providers;

- 2.12.12.2 In the event that a HCBS provider change is initiated for a member, require that, regardless of any other provision in the provider agreement, the transferring HCBS provider continue to provide services to the member in accordance with the member's plan of care until the member has been transitioned to a new provider, as determined by the CONTRACTOR, or as otherwise directed by the CONTRACTOR, which may exceed thirty (30) days from the date of notice to the CONTRACTOR;
- 2.12.12.3 Specify that reimbursement of a HCBS provider shall be contingent upon the provision of services to an eligible member in accordance with applicable federal and state requirements and the member's plan of care as authorized by the CONTRACTOR;
- 2.12.12.4 Require HCBS providers to immediately report any deviations from a member's service schedule to the member's care coordinator;
- 2.12.12.5 Require HCBS providers to use the electronic visit verification system specified by the CONTRACTOR in accordance with the CONTRACTOR's requirements;
- 2.12.12.6 Require that upon acceptance by the HCBS provider to provide approved services to a member as indicated in the member's plan of care, the provider shall ensure that it has staff sufficient to provide the service(s) authorized by the CONTRACTOR in accordance with the member's plan of care, including the amount, frequency, duration and scope of each service in accordance with the member's service schedule;
- 2.12.12.7 Require HCBS providers to provide back-up for their own staff if they are unable to fulfill their assignment for any reason and ensure that back-up staff meet the qualifications for the authorized service;
- 2.12.12.8 Prohibit HCBS providers from requiring a member to choose the provider as a provider of multiple services as a condition of providing any service to the member;
- 2.12.12.9 Require HCBS providers to comply with critical incident reporting and management requirements (see Section 2.15.7 of this Agreement); and
- 2.12.12.10 Shall not require the HCBS provider to have liability insurance in excess of TENNCARE requirements in effect prior to the implementation of CHOICES.
- 2.12.13 The provider agreement with a HCBS provider to provide PERS, assistive technology, minor home modifications, or pest control shall meet the requirements specified in Sections 2.12.9, 2.12.10, and 2.12.12 except that these provider agreements shall not be required to meet the following requirements: Section 2.12.9.9 regarding emergency services; Section 2.12.9.11 regarding delay in prenatal care; Section 2.12.9.12 regarding CLIA; Section 2.12.9.38 regarding hospital protocols; Section 2.12.9.40 regarding reimbursement of obstetric care; Section 2.12.9.52.2 regarding prior authorization of pharmacy; and Section 2.12.9.53 regarding coordination with the PBM.
- 2.12.14 The provider agreement with a local health department (see Section 2.11.7.3) shall meet the minimum requirements specified in Sections 2.12.9 and 2.12.10 above and shall also specify for the purpose of TENNderCare screening services: (1) that the

local health department agrees to submit encounter data timely to the CONTRACTOR; (2) that the CONTRACTOR agrees to timely process claims for services in accordance with Section 2.22.4; (3) that the local health department may terminate the agreement for cause with thirty (30) days advance notice; and (4) that the CONTRACTOR agrees prior authorization shall not be required for the provision of TENNderCare screening services.

2.12.15 The provider agreement for CRG/TPG assessments shall meet the minimum requirements specified in Sections 2.12.9 and 2.12.10 above and shall also specify that all CRG/TPG assessments detailed in Section 2.7.2.9 are completed by State-certified raters and that the assessments are completed within the specified time frames. The rater certification process shall include completing the CRG/TPG assessments training and passing the State rater competency examination, scored only by State-certified trainers.

15. Section 2.13 shall be amended by deleting Section 2.13 in its entirety and replacing it with the following and renumbering any references thereto:

2.13 PROVIDER AND SUBCONTRACTOR PAYMENTS

2.13.1 General

2.13.1.1 Maximum Allowable Rates

Providers shall be paid according to BlueCare policies and procedures and reimbursement rates in effect as of March 1, 2001, unless otherwise directed by TennCare with the following exceptions:

2.13.1.1.1 The payment rate for an initial TENNderCare screening conducted by a Best Practice Network Primary Care Provider for a child in State custody shall be at the rate specified in Section 2.13.2.1.

2.13.1.1.2 The payment rate for all other preventive health services specified below for children (under age 21) may be increased up to 85% of the 2001 Medicare fee-schedule, unless otherwise specified by TENNCARE.

2.13.1.1.2.1 The CONTRACTOR shall make an enhanced payment, defined as eighty-five percent (85%) of the 2001 Medicare fee-schedule or the BlueCare reimbursement rates in effect as of March 1, 2001, whichever is greater, to Primary Care Providers for the provision of the following preventive medical services identified by the CPT procedure codes listed below, when billed for children less than 21 years of age. Payment rates for services reimbursed as a percentage of average wholesale price shall be adjusted in accordance with Section 2.13.1.1.4 of this Agreement.

Office Visits

NEW PATIENT	ESTABLISHED PATIENT
99431 – History and Evaluation of Normal newborn	99391 – Periodic reevaluation
99432 – Normal Newborn care other than a hospital or birthing setting	99392 – age 1 through 4 years

NEW PATIENT	ESTABLISHED PATIENT
99381 – Initial evaluation	99393 – age 5 through 11 years
99382 – age 1 through 4 years	99394 – age 12 through 17 years
99383 – age 5 through 11 years	99395 – age 18 through 39 years
99384 – age 12 through 17 years	
99385 – age 18 through 39 years	

Counseling and Risk Factor Reduction Intervention

INDIVIDUAL	GROUP
99401 – approximately 15 minutes	99411 – approximately 30 minutes
99402 – approximately 30 minutes	99412 – approximately 60 minutes
99403 – approximately 45 minutes	
99404 – approximately 60 minutes	

Other Preventive Services

99420	Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal)
90700 – 90744	Immunizations
92551	Screening test, pure tone, air only (Audiologic function)
92552	Pure tone audiometry (threshold); air only

- 2.13.1.1.3 The payment rate for all services that are reimbursed as a percentage of average wholesale prices shall be adjusted with fluctuations in the average wholesale price. However, the “percentage” applied to determine the payment amount shall be equivalent to the percentage applied for BlueCare as of March 1, 2001.
- 2.13.1.1.4 The initial utilization management and referral processes and requirements impacting provider reimbursement shall be those in effect for BlueCare and TennCare Select as of July 1, 2001. However, the State reserves the right to require the CONTRACTOR to modify these processes and requirements. The CONTRACTOR shall have sixty (60) days from the date of request to implement requested modifications.
- 2.13.1.1.5 If there is a network deficiency that necessitates additional funding to remedy, the CONTRACTOR shall attempt to negotiate a reasonable rate on behalf of the State prior to recommending an increase in reimbursement rates. Once the negotiations are concluded, the CONTRACTOR shall submit a recommendation to the State in writing with supporting documentation justifying an increase in reimbursement rates. The CONTRACTOR may not implement a recommended change until receipt of written approval from TennCare.
- 2.13.1.2 Annual Review of Maximum Allowable Rates. The maximum allowable reimbursement rates shall be reviewed on an annual basis.

- 2.13.1.3 All reimbursement paid by the CONTRACTOR to providers and amounts paid by the CONTRACTOR to any other entity is subject to audit by the State. The CONTRACTOR shall allow for periodic review of records to ensure that all discounts, special pricing considerations and financial incentives have accrued to the State and that all costs incurred are in accordance with this Agreement. The CONTRACTOR shall provide the auditor access to all information necessary to perform the examination.
- 2.13.1.4 The claims payment amount shall not include payment for enrollee cost-sharing or patient liability amounts.
- 2.13.1.5 The CONTRACTOR shall require, as a condition of payment, that the provider (contract or non-contract provider) accept the amount paid by the CONTRACTOR or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payer) plus any applicable amount of TennCare cost sharing or patient liability responsibilities due from the enrollee as payment in full for the service.
- 2.13.1.6 If the CONTRACTOR is required to reimburse a non-contract provider pursuant to this Agreement, and the CONTRACTOR's payment to a non-contract provider is less than it would have been for a contract provider, and the provider contests the payment amount, the CONTRACTOR shall notify the non-contract provider that the provider may initiate the independent review procedures in accordance with TCA 56-32-126, including but not limited to reconsideration by the CONTRACTOR.
- 2.13.1.7 The CONTRACTOR shall ensure that the member is held harmless by the provider for the costs of medically necessary covered services except for applicable TennCare cost sharing amounts (described in Section 2.6.7 and in Attachment II of this Agreement) and patient liability amounts.
- 2.13.1.8 The CONTRACTOR shall ensure that payments are not issued to providers that have not obtained a Tennessee Medicaid provider number or for which disclosure requirements have not been obtained by the CONTRACTOR in accordance with 42 CFR 455.100 through 106 and Section 2.12.9.59 of this Agreement.
- 2.13.1.9 Except where required by this Agreement or by applicable federal or state law, rule or regulation, the CONTRACTOR shall not make payment for the cost of any medical care provided prior to the effective date of eligibility or after the termination date in the CONTRACTOR's MCO. The CONTRACTOR shall make payment for the cost of any covered services obtained on or after 12:01 a.m. on the effective date of eligibility in the CONTRACTOR's MCO.
- 2.13.1.10 The CONTRACTOR shall prepare checks for payment of providers for the provision of covered services on a weekly basis, unless an alternative payment schedule is approved by TENNCARE.
- 2.13.1.10.1 The CONTRACTOR shall notify the State of the amount to be paid in a mutually acceptable form and substance at least 72 hours in advance of distribution of provider checks.
- 2.13.1.10.2 The State shall release funds in the amount to be paid to providers to the CONTRACTOR. Funds shall be released within 72 hours of receipt of notice.

- 2.13.1.10.3 The CONTRACTOR shall release payments to providers within 24 hours of receipt of funds from the State.
- 2.13.1.10.4 The amount to be paid shall be reduced by the amount of third party recoveries captured in the claims processing system. The State shall release funds in the amount to be paid to providers to the CONTRACTOR.
- 2.13.1.11 For each request related to payments to providers through the CONTRACTOR's claims processing system, the CONTRACTOR shall provide a claims data extract in a format and media described by TENNCARE to support the payments released to providers by no later than seven (7) calendar days after the CONTRACTOR's request of the funds.
- 2.13.1.12 The CONTRACTOR shall provide a reconciliation for the total paid amounts between the funds released for payment to providers, the supporting claims data extract, and the encounter data submissions for the relevant adjudication cycle. The reconciliation should be submitted within seven (7) days of the claims data extract.
- 2.13.1.13 Upon notification by TENNCARE, funds released to the CONTRACTOR for purposes of provider payments shall be made based on the CONTRACTOR's encounter data. TENNCARE shall implement this process by initially making payments based on all encounters and providing the CONTRACTOR an error report of unacceptable encounter records. The final phase of implementation shall result in TENNCARE releasing funds based on clean encounters only. Once TENNCARE releases funds based solely on clean encounter data, the CONTRACTOR will no longer be required to submit the claims data extract. The reconciliation and check register must continue to be submitted on a weekly basis for the previous weeks check release.

2.13.2 **Best Practice Network Requirements**

2.13.2.1 Enhanced Initial TENNderCare Screening Rate

The CONTRACTOR shall make an enhanced payment to Best Practice Network Primary Care Providers and Health Departments for the initial TENNderCare examination for children in State custody, when all seven (7) components of the exam have been completed. The seven components shall include: (1) A comprehensive health and development history to include both physical and mental health; (2) Comprehensive unclothed physical exam; (3) Appropriate vision and hearing assessment; (4) Laboratory testes appropriate for age and risk; (5) Dental screening and referral beginning at age 3; (6) Immunizations; (7) Health education (anticipatory guidance).

2.13.2.1.1 The procedure codes to be utilized when billing for the initial TENNderCare exam are specified below. This language does not preclude the BPN-PCP from billing for other services separately, consistent with the CONTRACTOR’s procedures for claims processing (e.g., lab). It is the responsibility of the CONTRACTOR to include in its Best Practice Network provider agreements a requirement that all seven components of the TENNderCare exam are completed when an enhanced payment is made through a medical chart review. The CONTRACTOR should educate providers to document any barriers to completing all seven components (e.g. past history not available). The enhanced payment rate for the initial TENNderCare screening exam shall be ninety-five percent (95%) of the 2001 Medicare fee-schedule. Effective December 1, 2001, the enhanced fee schedule shall be 100% of the 2001 Medicare fee schedule unless otherwise specified by TENNCARE.

NEW PATIENT	ESTABLISHED PATIENT
99431 – History and Examination of Normal Newborn	99391 – Periodic reevaluation
99432 – Normal Newborn care other than a hospital or birthing setting	99392 – age 1 through 4 years
99381 – Initial evaluation	99393 – age 5 through 11 years
99382 – age 1 through 4 years	99394 – age 12 through 17 years
99383 – age 5 through 11 years	99395 – age 18 through 39 years
99384 – age 12 through 17 years	
99385 – age 18 through 39 years	

2.13.2.1.2 If the BPN-PCP submits a claim with a procedure code for an established patient, the CONTRACTOR may only reimburse the provider at the enhanced payment rate if the claim is for the initial TENNderCare exam upon placement in State custody. If the CONTRACTOR directs BPN-PCPs to only bill the initial TENNderCare exam with the New Patient procedure code series identified above, the CONTRACTOR must notify and provide appropriate training to the provider and provider’s billing staff to implement this billing procedure

2.13.2.2 Case Management

In exchange for performing additional care coordination and case management functions as specified in Section 3 of this Agreement, the CONTRACTOR shall pay Best Practice Network Primary Care Providers a case management fee of \$10.25 per member per month or the amount otherwise specified by TENNCARE.

2.13.3 **All Covered Services**

2.13.3.1 Except as provided in Sections 2.13.3.2 and 2.13.3.3 below, the CONTRACTOR shall not reimburse providers based on a percentage of billed charges.

2.13.3.2 The CONTRACTOR may, at its discretion, pay a percentage of billed charges for covered physical health and behavioral health services for which there is no Medicare reimbursement methodology.

- 2.13.3.3 As part of a stop-loss arrangement with a physical health or behavioral health provider, the CONTRACTOR may, at its discretion, pay the provider a percentage of billed charges for claims that exceed the applicable stop-loss threshold.

2.13.4 **Nursing Facility Services**

- 2.13.4.1 The CONTRACTOR shall reimburse contract nursing facility providers at the rate specified by TENNCARE, net of any applicable patient liability amount (see Section 2.6.7).
- 2.13.4.2 The CONTRACTOR shall reimburse non-contract nursing facility providers as specified in TennCare rules and regulations, net of any applicable patient liability amount (see Section 2.6.7).
- 2.13.4.3 If, prior to the end date specified by TENNCARE in its approval of Level II nursing facility services, the CONTRACTOR determines that the nursing facility is providing Level I and not Level II nursing facility services, the CONTRACTOR shall notify TENNCARE and, as appropriate, shall submit a request to modify the member's level of nursing facility services. The CONTRACTOR shall submit documentation as specified by TENNCARE to support the request. Upon approval from TENNCARE, the CONTRACTOR may adjust payment to the nursing facility to reflect the level of nursing facility services actually provided to the member and shall maintain documentation as specified by TENNCARE to support the payment adjustment.

2.13.5 **HCBS**

- 2.13.5.1 For covered HCBS provided to members in CHOICES Group 2 or 3 and for HCBS that exceed the specified benefit limit and are provided by the CONTRACTOR as a cost effective alternative to members in CHOICES Group 2 or 3 (see Section 2.6.5), the CONTRACTOR shall reimburse contract HCBS providers, including community-based residential alternatives, at the rate specified by TENNCARE.
- 2.13.5.2 The CONTRACTOR shall reimburse non-contract HCBS providers for services to members in CHOICES Group 2 or 3 as specified in TennCare rules and regulations.
- 2.13.5.3 For HCBS that are not otherwise covered but are offered by the CONTRACTOR to members in CHOICES Group 2 or 3 as a cost effective alternative to nursing facility services (see Section 2.6.5), the CONTRACTOR shall negotiate the rate of reimbursement.
- 2.13.5.4 The CONTRACTOR shall reimburse consumer-directed workers in accordance with Sections 2.9.6.7 and 2.26 of this Agreement.

2.13.6 **Hospice**

Hospice services shall be provided and reimbursed in accordance with state and federal requirements, including but not limited to the following:

- 2.13.6.1 Rates shall be no less than the federally established Medicaid hospice rates (updated each federal fiscal year (FFY)), adjusted by area wage adjustments for the categories described by CMS;

2.13.6.2 The rates described above shall be subject to the annual cap for Medicaid Hospice rates as provided annually by CMS; and

2.13.6.3 If a Medicaid hospice patient resides in a nursing facility (NF), the CONTRACTOR shall pay an amount equal to at least 95 percent of the prevailing NF room and board rate to the hospice provider (not subject to the annual cap for Medicaid Hospice rates).

2.13.7 Behavioral Health Crisis Service Teams

2.13.7.1 The CONTRACTOR shall reimburse crisis mobile teams for their intervention services. TennCare may require the CONTRACTOR to reimburse crisis mobile teams on a monthly basis at a rate to be determined and set by the State.

2.13.7.2 The CONTRACTOR shall negotiate rates for crisis respite and crisis stabilization services.

2.13.8 Local Health Departments

2.13.8.1 The CONTRACTOR shall reimburse contracted local health departments (see Sections 2.11.7.3 and 2.12.14) for TENNderCare screenings to members under age twenty-one (21) at the following rates, unless specified otherwise by TENNCARE. Although the codes include preventive visits for individuals twenty-one (21) and older, this Section only requires the CONTRACTOR to pay local health departments for the specified visits for members under age twenty-one (21).

Preventive Visits	85% of 2001 Medicare
99381 New pt. Up to 1 yr.	\$80.33
99382 New pt. 1- 4 yrs.	\$88.06
99383 New pt. 5 - 11yrs.	\$86.60
99384 New pt. 12 - 17yrs.	\$95.39
99385 New pt. 18 - 39 yrs.	\$93.93
99391 Estab. pt. Up to 1 yr.	\$63.04
99392 Estab. pt. 1 - 4 yrs.	\$71.55
99393 Estab. pt. 5 - 11yrs.	\$70.96
99394 Estab. pt. 12 - 17yrs.	\$79.57
99395 Estab. pt. 18 - 39 yrs.	\$78.99

2.13.8.2 TENNCARE may conduct an audit of the CONTRACTOR’s reimbursement methodology and related processes on an annual basis to verify compliance with this requirement. In addition, the Local Health Department may initiate the independent review procedure at any time it believes the CONTRACTOR’s payment is not the required reimbursement rate.

2.13.9 Physician Incentive Plan (PIP)

2.13.9.1 The CONTRACTOR shall notify and make TENNCARE and TDCI aware of any operations or plans to operate a physician incentive plan (PIP). Prior to

implementation of any such plans, the CONTRACTOR shall submit to TDCI any provider agreement templates or subcontracts that involve a PIP for review as a material modification.

- 2.13.9.2 The CONTRACTOR shall not implement a PIP in the absence of TDCI review and written approval.
- 2.13.9.3 If the CONTRACTOR operates a PIP, the CONTRACTOR shall ensure that no specific payment be made directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.
- 2.13.9.4 If the CONTRACTOR operates a PIP, upon TENNCARE's request, the CONTRACTOR shall report descriptive information about its incentive plan in sufficient detail to enable TENNCARE to adequately monitor the CONTRACTOR. The information that may be requested shall include, but not be limited to, the following:
 - 2.13.9.4.1 Whether services not furnished by the physician or physician group are covered by the incentive plan;
 - 2.13.9.4.2 The type or types of incentive arrangements, such as, withholds, bonus, capitation;
 - 2.13.9.4.3 The percent of any withhold or bonus the plan uses;
 - 2.13.9.4.4 Assurance that the physicians or physician group has adequate stop-loss protection, and the amount and type of stop-loss protection; and
 - 2.13.9.4.5 The patient panel size and, if the plan uses pooling, the pooling method.

2.13.10 Emergency Services Obtained from Non-Contract Providers

- 2.13.10.1 Payments to non-contract providers for emergency services may, at the CONTRACTOR's option, be limited to the treatment of emergency medical conditions, including post-stabilization care services, as described in Section 1. Payment amounts shall be consistent with the pricing policies developed by the CONTRACTOR and in accordance with TENNCARE requirements, including TennCare rules and regulations for emergency services provided by non-contract providers.
- 2.13.10.2 Payment by the CONTRACTOR for properly documented claims for emergency services rendered by a non-contract provider shall be made within thirty (30) calendar days of receipt of a clean claim by the CONTRACTOR.
- 2.13.10.3 The CONTRACTOR shall review and approve or disapprove claims for emergency services based on the definition of emergency services specified in Section 1 of this Agreement. If the CONTRACTOR determines that a claim requesting payment of emergency services does not meet the definition as specified in Section 1 and subsequently denies the claim, the CONTRACTOR shall notify the provider of the denial. This notification shall include information to the provider regarding the CONTRACTOR's process and time frames for reconsideration. In the event a

provider disagrees with the CONTRACTOR's decision to disapprove a claim for emergency services, the provider may pursue the independent review process for disputed claims as provided by TCA 56-32-126, including but not limited to reconsideration by the CONTRACTOR.

2.13.11 Medically Necessary Services Obtained from Non-Contract Provider when MCO Assignment is Unknown

2.13.11.1 The CONTRACTOR shall pay for medically necessary covered services provided to an enrollee by a non-contract provider when TENNCARE has enrolled the enrollee in the CONTRACTOR's MCO, but the enrollee could not have known which MCO they were enrolled in at the time of the service. Examples of when this may occur include, but are not limited to, (i) when an enrollee receives services during a retroactive eligibility period (see Section 2.4.5) and the enrollee did not select an MCO and is assigned to an MCO by TENNCARE, or (ii) the enrollee was assigned to an MCO other than the one that he/she requested (see Section 2.4.4.5). In these cases, the effective date of enrollment may occur prior to the CONTRACTOR or the enrollee being notified of the enrollee becoming a member of the CONTRACTOR's MCO.

2.13.11.2 When this situation arises, the CONTRACTOR shall not deny payment for medically necessary covered services provided during this period of eligibility for lack of prior authorization or lack of referral; likewise, the CONTRACTOR shall not deny a claim on the basis of the provider's failure to file a claim within a specified time period after the date of service when the provider could not have reasonably known which MCO the enrollee was in during the timely filing period. However, in such cases the CONTRACTOR may impose timely filing requirements beginning on the date of notification of the individual's enrollment.

2.13.11.3 The CONTRACTOR shall only pay for covered long-term care services for which the member was eligible (see Section 2.6), as determined by the State and shown in the enrollment file furnished by TENNCARE to the CONTRACTOR.

2.13.12 Medically Necessary Services Obtained from Contract Provider without Prior Authorization when MCO Assignment is Unknown

2.13.12.1 The CONTRACTOR shall pay for medically necessary covered services provided to an enrollee by a contract provider without prior authorization or referral when TENNCARE has enrolled the enrollee in the CONTRACTOR's MCO, but the enrollee could not have known which MCO they were enrolled in at the time of the service.

2.13.12.2 When this situation arises, the CONTRACTOR shall not deny payment for medically necessary covered services for lack of prior authorization or lack of referral; likewise, a CONTRACTOR shall not deny a claim on the basis of the provider's failure to file a claim within a specified time period after the date of service when the provider could not have reasonably known which MCO the enrollee was in during the timely filing period. However, in such cases the CONTRACTOR may impose timely filing requirements beginning on the date of notification of the individual's enrollment.

2.13.12.3 The CONTRACTOR shall only pay for covered long-term care services for which the member was eligible (see Section 2.6), as determined by the State and shown in the enrollment file furnished by TENNCARE to the CONTRACTOR.

2.13.13 Medically Necessary Services Obtained from Non-Contract Provider Referred by Contract Provider

The CONTRACTOR shall pay for any medically necessary covered services provided to a member by a non-contract provider at the request of a contract provider. The CONTRACTOR's payment shall not be less than eighty percent (80%) of the rate that would have been paid by the CONTRACTOR if the member had received the services from a contract provider. The CONTRACTOR shall only pay for covered long-term care services for which the member was eligible (see Section 2.6) and that were authorized by the CONTRACTOR.

2.13.14 Medically Necessary Services Obtained from Non-Contract Provider Not Authorized by the CONTRACTOR

2.13.14.1 With the exception of circumstances described in Section 2.13.13 when an enrollee has utilized medically necessary non-emergency covered services from a non-contract provider, and the CONTRACTOR has not authorized such use in advance, the CONTRACTOR shall not be required to pay for the service(s) received unless payment is required pursuant to a directive from TENNCARE or an Administrative Law Judge.

2.13.14.2 The CONTRACTOR shall not make payment to non-contract providers for covered services that are not medically necessary or for long-term care services for which the member was not eligible (see Section 2.6).

2.13.15 Covered Services Ordered by Medicare Providers for Dual Eligibles

2.13.15.1 Generally, when a TennCare enrollee is dually eligible for Medicare and TennCare and requires services that are covered under this Agreement but are not covered by Medicare, and the services are ordered by a Medicare provider who is a non-contract provider, the CONTRACTOR shall pay for the ordered, medically necessary service if it is provided by a contract provider. However, if all of the following criteria are met, the CONTRACTOR may require that the ordering physician be a contract provider:

2.13.15.1.1 The ordered service requires prior authorization; and

2.13.15.1.2 Dually eligible enrollees have been clearly informed of the contract provider requirement and instructed in how to obtain assistance identifying and making an appointment with a contract provider; and

2.13.15.1.3 The CONTRACTOR assists the enrollee in obtaining a timely appointment with a contract provider upon request of the enrollee or upon receipt of an order from a non-contract provider.

2.13.15.2 Reimbursement shall be at the same rate that would have been paid had the service been ordered by a contract provider.

2.13.15.3 The CONTRACTOR shall not pay for non-covered services, services that are not medically necessary, or services ordered and obtained from non-contract providers.

2.13.16 Transition of New Members

The CONTRACTOR shall pay for the continuation of covered services for new members pursuant to the requirements in Section 2.9.2 regarding transition of new members.

2.13.17 Transition of Members Receiving Long-Term Care Services at the Time of CHOICES Implementation

The CONTRACTOR shall pay for the continuation of covered long-term care services for transitioning CHOICES members pursuant to the requirements in Section 2.9.3 regarding transition of members receiving long-term care services at the time of CHOICES implementation.

2.13.18 Transition of Care

In accordance with the requirements in Section 2.9.4.1 of this Agreement, if a provider has terminated participation with the CONTRACTOR, the CONTRACTOR shall pay the non-contract provider for the continuation of treatment through the applicable period provided in Section 2.9.4.1.

2.13.19 Limits on Payments to Providers and Subcontractors Related to the CONTRACTOR

2.13.19.1 The CONTRACTOR shall not pay more for similar services rendered by any provider or subcontractor that is related to the CONTRACTOR than the CONTRACTOR pays to providers and subcontractors that are not related to the CONTRACTOR. For purposes of this subsection, "related to" means providers or subcontractors that have an indirect ownership interest or ownership or control interest in the CONTRACTOR, an affiliate (see definition in Section 1 of this Agreement) of the CONTRACTOR, or the CONTRACTOR's management company as well as providers or subcontractors that the CONTRACTOR, an affiliate of the CONTRACTOR or the CONTRACTOR's management company has an indirect ownership interest or ownership or control interest in. The standards and criteria for determining indirect ownership interest, an ownership interest or a control interest are set out at 42 CFR Part 455, Subpart B.

2.13.19.2 Any payments made by the CONTRACTOR that exceed the limitations set forth in this section shall be considered non-allowable payments for covered services and shall be excluded from medical expenses reported in the Medical Fund Target report required in Section 2.30.15.2.1.

2.13.19.3 As provided in Section 2.30.9 of this Agreement, the CONTRACTOR shall submit information on payments to related providers and subcontractors.

2.13.20 1099 Preparation

In accordance with federal requirements, the CONTRACTOR shall prepare and submit Internal Revenue Service (IRS) Form 1099s for all providers who are not employees of the CONTRACTOR to whom payment is made.

2.13.21 Payments to the FEA

The CONTRACTOR shall reimburse the Fiscal Employer Agent (FEA) for authorized HCBS provided by consumer-directed workers to members in CHOICES Group 2 or 3 as specified in the contract between the CONTRACTOR and the FEA. TENNCARE will pay the FEA the administrative fees specified in the contract between TENNCARE and the FEA.

2.13.22 Interest

Interest generated from the deposit of funds for provider payments shall be the property of the State. The amount of interest earned on the funds, as reported by the CONTRACTOR's bank on the monthly statement, shall be deducted from the amount of the next remittance request subsequent to receipt of the bank statement.

2.13.23 Immediate Eligibility

Medical service payments made in accordance with Section 2.13 shall include payments to providers for services provided during a period of Immediate Eligibility. However, in order to facilitate the invoicing of DCS for services provided to children in State custody who are not TennCare eligible, the CONTRACTOR shall submit to TENNCARE an itemized listing of claims paid on behalf children in State custody for whom Immediate Eligibility was established in accordance with this Agreement and who were not subsequently found to be TennCare eligible, on a monthly basis in the form and format specified in Attachment IX, Exhibit N.

16. Section 2.14 shall be amended by deleting Section 2.14 in its entirety and replacing it with the following and renumbering all references thereto:

2.14 UTILIZATION MANAGEMENT (UM)

2.14.1 General

2.14.1.1 The CONTRACTOR shall develop and maintain a utilization management (UM) program. As part of this program the CONTRACTOR shall have policies and procedures with defined structures and processes. The UM program shall assign responsibility to appropriate individuals including a designated senior physician and shall involve a designated behavioral health care practitioner in the implementation of behavioral health aspects of the program and, if and when directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, a designated long-term care professional in the implementation of the long-term care aspects of the program. The UM program shall be supported by an associated work plan and shall be evaluated annually and updated as necessary.

2.14.1.2 The CONTRACTOR's UM program shall include distinct policies and procedures regarding long-term care services and shall specify as applicable the responsibilities and scope of authority of care coordinators in authorizing long-term care services and in submitting service authorizations to providers and/or the FEA for service delivery.

2.14.1.3 The CONTRACTOR shall notify all contract providers of and enforce compliance with all provisions relating to UM procedures.

2.14.1.4 The UM program shall have criteria that:

- 2.14.1.4.1 Are objective and based on medical, behavioral health and/or long-term care evidence, to the extent possible;
- 2.14.1.4.2 Are applied based on individual needs;
- 2.14.1.4.3 Are applied based on an assessment of the local delivery system;
- 2.14.1.4.4 Involve appropriate practitioners in developing, adopting and reviewing them; and
- 2.14.1.4.5 Are annually reviewed and up-dated as appropriate.
- 2.14.1.5 For long-term care services, the CONTRACTOR's UM program shall have criteria that are consistent with the guiding principles set forth in TCA 71-5-1402 and shall take into consideration the member's preference regarding cost-effective long-term care services and settings.
- 2.14.1.6 The CONTRACTOR shall use appropriately licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each level of UM, including prior authorization and decision making. The CONTRACTOR shall have written procedures documenting access to Board Certified Consultants to assist in making medical necessity determinations. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a physical health or behavioral health care professional who has appropriate clinical expertise in treating the member's condition or disease or, in the case of long-term care services, a long-term care professional who has appropriate expertise in providing long-term care services.
- 2.14.1.7 Except as provided in Section 2.6.1.4, the CONTRACTOR shall not place maximum limits on the length of stay for members requiring hospitalization and/or surgery. The CONTRACTOR shall not employ, and shall not permit others acting on their behalf to employ utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each member and his/her medical history. The CONTRACTOR shall consider individual member characteristics in the determination of readiness for discharge. This requirement is not intended to limit the ability of the CONTRACTOR to use clinical guidelines or criteria in placing tentative limits on the length of a prior authorization or pre-admission certification.
- 2.14.1.8 The CONTRACTOR shall have mechanisms in place to ensure that required services are not arbitrarily denied or reduced in amount, duration, or scope solely because of the diagnosis, type of illness, or condition.
- 2.14.1.9 The CONTRACTOR shall assure, consistent with 42 CFR 438.6(h), 42 CFR 422.208 and 422.210, that compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member.

2.14.1.10 As part of the provider survey required by Section 2.18.7.4, the CONTRACTOR shall assess provider/office staff satisfaction with UM processes to identify areas for improvement.

2.14.1.11 Inpatient Care

The CONTRACTOR shall provide for methods of assuring the appropriateness of inpatient care. Such methodologies shall be based on individualized determinations of medical necessity in accordance with UM policies and procedures and, at a minimum, shall include the items specified in subparagraphs 2.14.1.11.1 through 2.14.1.11.5 below:

2.14.1.11.1 Pre-admission certification process for non-emergency admissions;

2.14.1.11.2 A concurrent review program to monitor and review continued inpatient hospitalization, length of stay, or diagnostic ancillary services regarding their appropriateness and medical necessity. In addition, the CONTRACTOR shall have a process in place to determine for emergency admissions, based upon medical criteria, if and when a member can be transferred to a contract facility in the network, if presently in a non-contract facility;

2.14.1.11.3 Admission review for urgent and/or emergency admissions, on a retroactive basis when necessary, in order to determine if the admission is medically necessary and if the requested length of stay for the admission is reasonable based upon an individualized determination of medical necessity. Such reviews shall not result in delays in the provision of medically necessary urgent or emergency care;

2.14.1.11.4 Restrictions against requiring pre-admission certification for admissions for the normal delivery of children; and

2.14.1.11.5 Prospective review of same day surgery procedures.

2.14.1.12 Nursing Facility

2.14.1.12.1 If a member is enrolled in CHOICES Group 1, the CONTRACTOR shall authorize and initiate nursing facility services for that member in accordance with Section 2.9.6. However, if, prior to nursing facility admission, the member chooses to receive HCBS instead of nursing facility services and is enrolled in CHOICES Group 2 pursuant to Section 2.9.6, the CONTRACTOR shall authorize and initiate HCBS in accordance with Section 2.9.6. Once the member has been admitted to a nursing facility the CONTRACTOR may, as appropriate, implement its nursing facility-to-community transition process pursuant to Section 2.9.6.8 of this Agreement.

2.14.1.12.2 The CONTRACTOR shall ensure that CHOICES members who have been determined by TENNCARE to be eligible for Level II nursing facility care are authorized to receive Level II nursing facility care for the period specified by TENNCARE. The CONTRACTOR shall monitor the member's condition, and if the CONTRACTOR determines that, prior to the end date specified by TENNCARE, the member no longer requires Level II nursing facility care, the CONTRACTOR may submit to TENNCARE a request to modify the member's level of nursing facility services. The CONTRACTOR shall submit documentation as specified by

TENNCARE to support the request and shall only transition the member to Level I nursing facility care once the request has been approved by TENNCARE.

2.14.1.13 Emergency Department (ED) Utilization

The CONTRACTOR shall utilize the following guidelines in identifying and managing care for members who are determined to have excessive and/or inappropriate ED utilization:

2.14.1.13.1 Review ED utilization data, at a minimum, every six (6) months (in January and July) to identify members with utilization exceeding the threshold defined by TENNCARE in the preceding six (6) month period. The January review shall cover ED utilization during the preceding April through September; the July review shall cover ED utilization during the preceding October through March;

2.14.1.13.2 Enroll non-CHOICES members whose utilization exceeds the threshold of ED visits defined by TENNCARE in the previous six (6) month period in MCO case management and may use the information to identify members who may be eligible for CHOICES in accordance with the requirements in Section 2.9.6.3 if appropriate;

2.14.1.13.3 For CHOICES members whose utilization exceeds the threshold of ED visits defined by TENNCARE in the previous six (6) month period, the care coordinator shall conduct appropriate follow-up to identify the issues causing frequent ED utilization and determine appropriate next steps. For members in CHOICES Group 1, appropriate next steps may include communication with the nursing facility to determine interventions to better manage the member's condition. For members in CHOICES Groups 2 and 3, appropriate next steps may include modifications to the member's plan of care in order to address service delivery needs and better manage the member's condition.

2.14.1.13.4 As appropriate, make contact with members whose utilization exceeded the threshold of ED visits defined by TENNCARE in the previous six (6) month period and their primary care providers for the purpose of providing education on appropriate ED utilization; and

2.14.1.13.5 Assess the most likely cause of high utilization and develop an MCO case management plan based on results of the assessment for each non-CHOICES member.

2.14.1.14 Hospitalizations and Surgeries

The CONTRACTOR shall comply with any applicable federal and state laws or rules related to length of hospital stay. TENNCARE will closely monitor encounter data related to length of stay and re-admissions to identify potential problems. If indicated, TENNCARE may conduct special studies to assess the appropriateness of hospital discharges.

2.14.2 Prior Authorization for Physical Health and Behavioral Health Covered Services

2.14.2.1 The CONTRACTOR shall have in place, and follow, written policies and procedures for processing requests for initial and continuing prior authorizations of services and

have in effect mechanisms to ensure consistent application of review criteria for prior authorization decisions. The policies and procedures shall provide for consultation with the requesting provider when appropriate. If prior authorization of a service is granted by the CONTRACTOR and the service is provided, payment for the prior authorized service shall not be denied based on the lack of medical necessity, assuming that the member is eligible on the date of service, unless it is determined that the facts at the time of the denial of payment are significantly different than the circumstances which were described at the time that prior authorization was granted.

2.14.2.2 Prior authorization for home health nurse, home health aide and private duty nursing services shall comply with TennCare rules and regulations.

2.14.2.3 Prior authorization requests shall be reviewed subject to the guidelines described in TennCare rules and regulations which include, but are not limited to, provisions regarding decisions, notices, medical contraindication, and the failure of an MCO to act timely upon a request.

2.14.3 **Referrals for Physical Health and Behavioral Health**

2.14.3.1 Except as provided in Section 2.14.4, the CONTRACTOR may require members to seek a referral from their PCP prior to accessing non-emergency specialty physical health services.

2.14.3.2 If the CONTRACTOR requires members to obtain PCP referral, the CONTRACTOR may exempt certain services, identified by the CONTRACTOR in the member handbook, from PCP referral.

2.14.3.3 For members determined to need a course of treatment or regular care monitoring, the CONTRACTOR shall have a mechanism in place to allow members to directly access a specialist as appropriate for the members' condition and identified needs.

2.14.3.4 The CONTRACTOR shall not require that a woman go in for an office visit with her PCP in order to obtain the referral for prenatal care.

2.14.3.5 Referral Provider Listing

2.14.3.5.1 The CONTRACTOR shall provide all PCPs with a current hard copy listing of referral providers, including behavioral health providers at least thirty (30) calendar days prior to the start date of operations. Thereafter the CONTRACTOR shall mail PCPs an updated version of the listing on a quarterly basis. The CONTRACTOR shall also maintain an updated electronic, web-accessible version of the referral provider listing.

2.14.3.5.2 The referral provider listing shall be in the format specified by TENNCARE for the provider directory in Section 2.17.8.

2.14.3.5.3 As required in Section 2.30.10.7, the CONTRACTOR shall submit to TENNCARE a copy of the referral provider listing, a data file of the provider information in a media and format described by TENNCARE, and documentation regarding mailing.

2.14.4 Exceptions to Prior Authorization and/or Referrals for Physical Health and Behavioral Health

2.14.4.1 Emergency and Post-Stabilization Care Services

The CONTRACTOR shall provide emergency services without requiring prior authorization or PCP referral, as described in Section 2.7.1, regardless of whether these services are provided by a contract or non-contract provider. The CONTRACTOR shall provide post-stabilization care services (as defined in Section 1) in accordance with 42 CFR 422.113.

2.14.4.2 TENnderCare

The CONTRACTOR shall not require prior authorization or PCP referral for the provision of TENnderCare screening services.

2.14.4.3 Access to Women's Health Specialists

The CONTRACTOR shall allow female members direct access (without requiring a referral) to a women's health specialist who is a contract provider for covered services necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist.

2.14.4.4 Behavioral Health Services

The CONTRACTOR shall not require a PCP referral for members to access a behavioral health provider.

2.14.4.5 Transition of New Members

Pursuant to the requirements in Section 2.9.2 regarding transition of new members, the CONTRACTOR shall provide for the continuation of medically necessary covered services regardless of prior authorization or referral requirements. However, as provided in Section 2.9.2, in certain circumstances the CONTRACTOR may require prior authorization for continuation of services beyond the initial thirty (30) days.

2.14.5 Authorization of Long-Term Care Services

2.14.5.1 The CONTRACTOR shall have in place an authorization process for all applicable covered long-term care services and cost effective alternative services that is separate from but integrated with the CONTRACTOR's prior authorization process for covered physical health and behavioral health services (see Section 2.9.6 of this Agreement).

2.14.5.2 The CONTRACTOR shall authorize and initiate all long-term care services for CHOICES members within the timeframes specified in Sections 2.9.2, 2.9.3, and 2.9.6 of this Agreement.

2.14.5.3 The CONTRACTOR shall not require that HCBS be ordered by a treating physician, but may consult with the treating physician as appropriate regarding the member's physical health, behavioral health, and long-term care needs and in order to facilitate communication and coordination regarding the member's physical health, behavioral health, and long-term care services.

2.14.5.4 For non-CHOICES members receiving care in non-contract nursing facilities authorized by the CONTRACTOR as a cost-effective alternative, the CONTRACTOR shall reimburse services in accordance with its authorization until such time that the member is no longer eligible for services, is enrolled in CHOICES, or such care is no longer medically necessary or cost-effective.

2.14.6 Transition of Members Receiving Long-Term Care Services at the Time of CHOICES Implementation

For members enrolling in CHOICES as of the date of CHOICES implementation, the CONTRACTOR shall be responsible for continuing to provide the long-term care services previously authorized for the member, as specified in Section 2.9.3 of this Agreement.

2.14.7 Notice of Adverse Action Requirements

2.14.7.1 The CONTRACTOR shall clearly document and communicate the reasons for each denial of a prior authorization request in a manner sufficient for the provider and member to understand the denial and decide about requesting reconsideration of or appealing the decision.

2.14.7.2 The CONTRACTOR shall comply with all member notice provisions in TennCare rules and regulations.

2.14.7.3 The CONTRACTOR shall issue appropriate notice prior to any CONTRACTOR-initiated decision to reduce or terminate CHOICES or non-CHOICES nursing facility services and shall comply with all federal court orders, and federal and state laws and regulations regarding members' transfer or discharge from nursing facilities.

2.14.8 Medical History Information Requirements

2.14.8.1 The CONTRACTOR is responsible for eliciting pertinent medical history information from the treating provider(s), as needed, for purposes of making medical necessity determinations. With respect to HCBS which are not primarily medical in nature, pertinent medical history shall include assessments, case notes, and documentation of service delivery by HCBS providers. Medical information from the treating physician may also be pertinent in better understanding the member's functional needs. The CONTRACTOR shall take action (e.g., sending a CONTRACTOR representative to obtain the information and/or discuss the issue with the provider, imposing financial penalties against the provider, etc.), to address the problem if a treating provider is uncooperative in supplying needed information. The CONTRACTOR shall make documentation of such action available to TENNCARE, upon request. Providers who do not provide requested information for purposes of making a medical necessity determination for a particular item or service shall not be entitled to payment for the provision of such item or service.

2.14.8.2 Upon request by TENNCARE, the CONTRACTOR shall provide TENNCARE with individualized medical record information from the treating provider(s). The CONTRACTOR shall take whatever action necessary to fulfill this responsibility within the required appeal time lines as specified by TENNCARE and/or applicable TennCare rules and regulations, up to and including going to the provider's office to obtain the medical record information. Should a provider fail or refuse to respond to the CONTRACTOR's efforts to obtain medical information, and the appeal is decided in favor of the member, at the CONTRACTOR's discretion or a directive by TENNCARE, the CONTRACTOR shall impose financial penalties against the provider as appropriate.

2.14.9 **PCP Profiling**

The CONTRACTOR shall profile its PCPs. Further, the CONTRACTOR shall investigate the circumstances surrounding PCPs who appear to be operating outside peer norms and shall intervene, as appropriate, when utilization or quality of care issues are identified. As part of these profiling activities, the CONTRACTOR shall analyze utilization data, including but not limited to, information provided to the CONTRACTOR by TENNCARE, and report back information as requested by TENNCARE. PCP profiling shall include, but not be limited to the following areas:

2.14.9.1 Utilization of Non-Contract Providers

The CONTRACTOR shall maintain a procedure to identify and evaluate member utilization of services provided by non-contract providers by PCP panel.

2.14.9.2 Specialist Referrals

The CONTRACTOR shall maintain a procedure to identify and evaluate member specialty provider utilization by PCP panel.

2.14.9.3 Emergency Room Utilization

The CONTRACTOR shall maintain a procedure to identify and evaluate member emergency room utilization by PCP panel. As provided in Section 2.9.5, members who establish a pattern of accessing emergency room services shall be referred to MCO case management as appropriate for follow-up.

2.14.9.4 Inpatient Admissions

The CONTRACTOR shall maintain a procedure to identify and evaluate member utilization of inpatient services by PCP panel.

2.14.9.5 Pharmacy Utilization

At a minimum, the CONTRACTOR shall profile PCP prescribing patterns for generic versus brand name and the number of narcotic prescriptions written. In addition, the CONTRACTOR shall comply with the requirements in Section 2.9.10 of this Agreement.

2.14.9.6 Advanced Imaging Procedures

The CONTRACTOR shall profile the utilization of advanced imaging procedures by PCP panel. Advanced imaging procedures include: PET Scans; CAT Scans and MRIs.

2.14.9.7 PCP Visits

The CONTRACTOR shall profile the average number of visits per member assigned to each PCP.

17. Section 2.15 shall be amended by deleting Section 2.15 in its entirety and replacing it with the following and renumbering all references thereto:

2.15 QUALITY MANAGEMENT/QUALITY IMPROVEMENT

2.15.1 Quality Management/Quality Improvement (QM/QI) Program

2.15.1.1 The CONTRACTOR shall have a written Quality Management/Quality Improvement (QM/QI) program that clearly defines its quality improvement structures and processes and assigns responsibility to appropriate individuals. This document shall include a separate section on CHOICES care coordination and must include all of the elements listed below. This QM/QI program shall use as a guideline the current NCQA Standards and Guidelines for the Accreditation of MCOs and shall include the CONTRACTOR's plan for improving patient safety. This means at a minimum that the QM/QI program shall:

2.15.1.1.1 Address physical health, behavioral health, and long-term care services;

2.15.1.1.2 Be accountable to the CONTRACTOR's board of directors and executive management team;

2.15.1.1.3 Have substantial involvement of a designated physician and designated behavioral health practitioner;

2.15.1.1.4 Any changes to the QM/QI program structure, including that of CHOICES, shall require prior written approval from TENNCARE. The QM/QI program description, associated work plan, and annual evaluation of the QM/QI Program shall be submitted to TENNCARE as required in Section 2.30.11.1, Reporting Requirements. All three of these documents shall include CHOICES information;

2.15.1.1.5 Have an annual work plan;

2.15.1.1.6 Have resources – staffing, data sources and analytical resources – devoted to it; and

2.15.1.1.7 Be evaluated annually and updated as appropriate.

2.15.1.2 The CONTRACTOR shall make all information about its QM/QI program available to providers and members.

- 2.15.1.3 As part of the QM/QI program, the CONTRACTOR shall collect information on providers' actions to improve patient safety and make performance data available to providers and members.
- 2.15.1.4 Any changes to the QM/QI program structure shall require prior written approval from TENNCARE. The QM/QI program description, associated work plan, and annual evaluation of the QM/QI Program shall be submitted to TENNCARE as required in Section 2.30.11.1, Reporting Requirements.
- 2.15.1.5 The CONTRACTOR shall use the results of QM/QI activities to improve the quality of physical health, behavioral health, and long-term care service delivery with appropriate input from providers and members.
- 2.15.1.6 The CONTRACTOR shall take appropriate action to address service delivery, provider, and other QM/QI issues as they are identified.
- 2.15.1.7 In addition to QM/QI activities as defined in this Section 2.15, the CONTRACTOR's QM/QI program shall incorporate all applicable reporting and monitoring requirements and activities, including but not limited to such activities specified in Sections 2.25, 2.30, and 2.9.6.12 of this Agreement; and shall include discovery and remediation of individual findings, as well as identification and implementation of strategies to make systemic improvements in the delivery and quality of care.

2.15.2 QM/QI Committee

- 2.15.2.1 The CONTRACTOR shall have a QM/QI committee which shall include medical, behavioral health, and long-term care staff and contract providers (including medical, behavioral health, and long-term care providers). This committee shall analyze and evaluate the results of QM/QI activities, recommend policy decisions, ensure that providers are involved in the QM/QI program, institute needed action, and ensure that appropriate follow-up occurs. This committee shall also review and approve the QM/QI program description and associated work plan prior to submission to TENNCARE as required in Section 2.30.11.1, Reporting Requirements.
- 2.15.2.2 The QM/QI committee shall keep written minutes of all meetings. A copy of the signed and dated written minutes for each meeting shall be available on-file after the completion of the following committee meeting in which the minutes are approved and shall be available for review upon request and during the annual on-site EQRO review and/or NCQA accreditation review.
- 2.15.2.3 The CONTRACTOR shall provide the Chief Medical Officer of TENNCARE with ten (10) calendar days advance notice of all regularly scheduled meetings of the QM/QI committee. To the extent allowed by law, the Chief Medical Officer of TENNCARE, or his/her designee, may attend the QM/QI committee meetings at his/her option.

2.15.3 Performance Improvement Projects (PIPs)

- 2.15.3.1 The CONTRACTOR shall perform at least two (2) clinical and three (3) non-clinical PIPs using existing processes, methodologies, and protocols, including the CMS protocols.
 - 2.15.3.1.1 The two (2) clinical PIPs shall include one (1) in the area of behavioral health. The behavioral health PIP shall be relevant to one of the behavioral health disease management programs for bipolar disorder, major depression, or schizophrenia.
 - 2.15.3.1.2 If and when directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, two (2) of the three (3) non-clinical PIPs shall be in the area of long-term care.
- 2.15.3.2 The CONTRACTOR shall ensure that CMS protocols for PIPs are followed and that the following are documented for each activity:
 - 2.15.3.2.1 Rationale for selection as a quality improvement activity;
 - 2.15.3.2.2 Specific population targeted, include sampling methodology if relevant;
 - 2.15.3.2.3 Metrics to determine meaningful improvement and baseline measurement;
 - 2.15.3.2.4 Specific interventions (enrollee and provider);
 - 2.15.3.2.5 Relevant clinical practice guidelines; and
 - 2.15.3.2.6 Date of re-measurement.
- 2.15.3.3 The CONTRACTOR shall identify benchmarks and set achievable performance goals for each of its PIPs. The CONTRACTOR shall identify and implement intervention and improvement strategies for achieving the performance goal set for each PIP and promoting sustained improvements.
- 2.15.3.4 The CONTRACTOR shall report on PIPs as required in Section 2.30.11.2, Reporting Requirements.
- 2.15.3.5 After three (3) years, the CONTRACTOR shall, using evaluation criteria established by TENNCARE, determine if one or all of the non-long-term care PIPs should be continued. Prior to discontinuing a non-long-term care PIP, the CONTRACTOR shall identify a new PIP and must receive TENNCARE's approval to discontinue the previous PIP and perform the new PIP.

2.15.4 Clinical Practice Guidelines

The CONTRACTOR shall utilize evidence-based clinical practice guidelines in its disease management programs. The guidelines shall be reviewed and revised at least every two (2) years or whenever the guidelines change.

2.15.5 NCQA Accreditation

- 2.15.5.1 The CONTRACTOR shall maintain NCQA accreditation throughout the period of this Agreement.
- 2.15.5.2 Following accreditation or re-accreditation, the CONTRACTOR must submit a copy of the bound report from NCQA” within 10 days of receipt of the report.
- 2.15.5.3 Failure to maintain NCQA Accreditation shall be considered a breach of this Agreement and shall result in termination of this Agreement in accordance with the terms set forth in Section 5.4 of this Agreement. Achievement of provisional accreditation status shall require a corrective action plan within thirty (30) calendar days of receipt of notification from NCQA and may result in termination of this Agreement in accordance with Section 5.4 of this Agreement.

2.15.6 HEDIS and CAHPS

- 2.15.6.1 Annually, the CONTRACTOR shall complete all HEDIS measures designated by NCQA as relevant to Medicaid. The only exclusion from the complete Medicaid HEDIS data set shall be dental measures. The CONTRACTOR shall contract with an NCQA certified HEDIS auditor to validate the processes of the CONTRACTOR in accordance with NCQA requirements. Audited HEDIS results shall be submitted to TENNCARE, NCQA and TENNCARE’s EQRO annually by June 15 of each calendar year.
- 2.15.6.2 Annually, the CONTRACTOR shall conduct a CAHPS survey. The CONTRACTOR shall enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys. The CONTRACTOR’s vendor shall perform the CAHPS adult survey, CAHPS child survey and the CAHPS children with chronic conditions survey. Survey results shall be reported to TENNCARE separately for each required CAHPS survey listed above. Survey results shall be submitted to TENNCARE, NCQA and TENNCARE’s EQRO annually by June 15 of each calendar year.

2.15.7 Critical Incident Reporting and Management for Members in CHOICES Groups 2 or 3

- 2.15.7.1 Unless and until directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the requirements in Section 2.15.7 shall not apply. When directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the CONTRACTOR shall develop and implement a critical incident reporting and management system for incidents that occur in a home and community-based long-term care service delivery setting, including: community-based residential alternatives; adult day care centers; other HCBS provider sites; and a member’s home, if the incident is related to the provision of covered HCBS.
- 2.15.7.2 The CONTRACTOR shall identify and track critical incidents and shall review and analyze critical incidents to identify and address potential and actual quality of care and/or health and safety issues. The CONTRACTOR shall regularly review the number and types of incidents (including, for example, the number and type of incidents across settings, providers, and provider types) and findings from investigations (including findings from APS and CPS if available); identify trends

and patterns; identify opportunities for improvement; and develop and implement strategies to reduce the occurrence of incidents and improve the quality of HCBS.

- 2.15.7.3 Critical incidents shall include but not be limited to the following incidents when they occur in a home and community-based long-term care service delivery setting (as defined in Section 2.15.7.1 above):
 - 2.15.7.3.1 Unexpected death of a CHOICES member;
 - 2.15.7.3.2 Suspected physical or mental abuse of a CHOICES member;
 - 2.15.7.3.3 Theft or financial exploitation of a CHOICES member;
 - 2.15.7.3.4 Severe injury sustained by a CHOICES member;
 - 2.15.7.3.5 Medication error involving a CHOICES member;
 - 2.15.7.3.6 Sexual abuse and/or suspected sexual abuse of a CHOICES member; and
 - 2.15.7.3.7 Abuse and neglect and/or suspected abuse and neglect of a CHOICES member.
- 2.15.7.4 The CONTRACTOR shall require its staff and contract HCBS providers to report, respond to, and document critical incidents as specified by the CONTRACTOR. This shall include, but not be limited to the following:
 - 2.15.7.4.1 Requiring that the CONTRACTOR's staff and contract HCBS providers report critical incidents to the CONTRACTOR in accordance with applicable requirements. The CONTRACTOR shall develop and implement a critical incident reporting process, including the form to be used to report critical incidents and reporting timeframes. The maximum timeframe for reporting an incident to the CONTRACTOR shall be twenty-four (24) hours. The initial report of an incident within twenty-four (24) hours may be submitted verbally, in which case the person/agency/entity making the initial report shall submit a follow-up written report within forty-eight (48) hours.
 - 2.15.7.4.2 Requiring that suspected abuse, neglect, and exploitation of members who are adults is immediately reported in accordance with TCA 71-6-103 and suspected brutality, abuse, or neglect of members who are children is immediately reported in accordance with TCA 37-1-403 or TCA 37-1-605 as applicable.
 - 2.15.7.4.3 Requiring that its staff and contract HCBS providers immediately (which shall not exceed twenty-four hours) take steps to prevent further harm to any and all members and respond to any emergency needs of members.
 - 2.15.7.4.4 Requiring that contract HCBS providers with a critical incident conduct an internal critical incident investigation and submit a report on the investigation within the timeframe specified by the CONTRACTOR. The timeframe for submitting the report shall be as soon as possible, may be based on the severity of the incident, and, except under extenuating circumstances, shall be no more than thirty (30) days after the date of the incident. The CONTRACTOR shall review the provider's report and follow-up

with the provider as necessary to ensure that an appropriate investigation was conducted and corrective actions were implemented within applicable timeframes.

- 2.15.7.4.5 Requiring that its staff and contract HCBS providers cooperate with any investigation conducted by the CONTRACTOR or outside agencies (e.g., TENNCARE, APS, CPS, and law enforcement).
- 2.15.7.4.6 Defining the role and responsibilities of the fiscal employer agent (see definition in Section 1) in reporting, responding to, documenting, and investigating any critical incidents, which shall include reporting incidents to the CONTRACTOR using the process developed in accordance with Section 2.15.7.4.1, investigating critical incidents, submitting a report on investigations to the CONTRACTOR and reporting to the CONTRACTOR within 24 hours in accordance with the abuse and neglect plan protocols anytime there is a suspicion of abuse or neglect (see Section 2.9.7.8.6); training employees, contractors of the FEA (including supports brokers), and consumer-directed workers regarding reporting, responding to, documenting, and cooperating with the investigation of any critical incidents; and training consumers and caregivers regarding critical incident reporting and management. Such role and responsibilities shall be defined in a manner that is consistent with requirements in this Section 2.15.7.4 as well as TENNCARE's contract with the fiscal employer agent and the model contract between the CONTRACTOR and the FEA.
- 2.15.7.4.7 Reviewing the FEA's reports and investigations regarding critical incidents and follow-up with the FEA as necessary regarding corrective actions determined by the member and/or his/her representative to help ensure the member's health and safety.
- 2.15.7.4.8 Providing appropriate training and taking corrective action as needed to ensure its staff, contract HCBS providers, the FEA, and workers comply with critical incident requirements.
- 2.15.7.4.9 Conducting oversight, including but not limited to oversight of its staff, contract HCBS providers, and the FEA, to ensure that the CONTRACTOR's policies and procedures are being followed and that necessary follow-up is being conducted in a timely manner.
- 2.15.7.5 The CONTRACTOR shall report to TENNCARE any death and any incident that could significantly impact the health or safety of a member (e.g., physical or sexual abuse) within twenty-four (24) hours of detection or notification.
- 2.15.7.6 As specified in Section 2.30.11.6, the CONTRACTOR shall submit monthly reports to TENNCARE regarding all critical incidents.

18. Section 2.17 shall be amended by deleting Section 2.17 in its entirety and replacing it with the following and renumbering all references thereto:

2.17 MEMBER MATERIALS

2.17.1 Prior Approval Process for All Member Materials

- 2.17.1.1 The CONTRACTOR shall submit to TENNCARE for review and prior written approval all materials that will be distributed to members (referred to as member materials) as well as proposed health education and outreach activities. This includes but is not limited to member handbooks, provider directories, member newsletters, identification cards, fact sheets, notices, brochures, form letters, mass mailings, member education and outreach activities as described in this Section, Section 2.17 and Section 2.7.4, system generated letters and any other additional, but not required, materials and information provided to members designed to promote health and/or educate members.
- 2.17.1.2 All member materials shall be submitted to TENNCARE on paper and electronic file media, in the format prescribed by TENNCARE. The materials shall be accompanied by a plan that describes the CONTRACTOR's intent and procedure for the use of the materials. Materials developed by a recognized entity having no association with the CONTRACTOR that are related to management of specific types of diseases (e.g., heart, diabetes, asthma, etc.) or general health improvement shall be submitted for approval; however, unless otherwise requested by TENNCARE, an electronic file for these materials is not required. The electronic files shall be submitted in a format acceptable to TENNCARE. Electronic files submitted in any other format than those approved by TENNCARE will not be processed.
- 2.17.1.3 TENNCARE shall review the submitted member materials and either approve or deny them within fifteen (15) calendar days from the date of submission. In the event TENNCARE does not approve the materials TENNCARE may provide written comments, and the CONTRACTOR shall resubmit the materials.
- 2.17.1.4 Once member materials have been approved in writing by TENNCARE, the CONTRACTOR shall submit to TENNCARE an electronic version (PDF) of the final printed product, unless otherwise specified by TENNCARE, within thirty (30) calendar days from the print date. Should TENNCARE request original prints be submitted in hard copy, photo copies may not be submitted as a final product. Upon request, the CONTRACTOR shall provide additional original prints of the final product to TENNCARE.
- 2.17.1.5 Prior to modifying any approved member material, the CONTRACTOR shall submit for written approval by TENNCARE a detailed description of the proposed modification. Proposed modifications shall be submitted in accordance with the requirements herein.
- 2.17.1.6 TENNCARE reserves the right to notify the CONTRACTOR to discontinue or modify member materials after approval.

2.17.2 Written Material Guidelines

The CONTRACTOR shall comply with the following requirements as it relates to written member materials:

- 2.17.2.1 All member materials shall be worded at a sixth (6th) grade reading level, unless TENNCARE approves otherwise;
- 2.17.2.2 All written materials shall be clearly legible with a minimum font size of 12pt. with the exception of member I.D. cards, and unless otherwise approved in writing by TENNCARE;
- 2.17.2.3 All written materials shall be printed with the assurance of non-discrimination as provided in Section 5.32;
- 2.17.2.4 The following shall not be used on any written materials, including but not limited to member materials, without the written approval of TENNCARE:
 - 2.17.2.4.1 The Seal of the State of Tennessee;
 - 2.17.2.4.2 The TennCare name unless the initials “SM” denoting a service mark, is superscripted to the right of the name (TennCaresm);
 - 2.17.2.4.3 The word “free” unless the service is at no cost to all members. If members have cost sharing or patient liability responsibilities, the service is not free. Any conditions of payments shall be clearly and conspicuously disclosed in close proximity to the “free” good or service offer; and
 - 2.17.2.4.4 The use of phrases to encourage enrollment such as “keep your doctor” implying that enrollees can keep all of their providers. Enrollees in TennCare shall not be led to think that they can continue to go to their current provider, unless that particular provider is a contract provider with the CONTRACTOR’s MCO;
- 2.17.2.5 All vital CONTRACTOR documents shall be translated and available in Spanish. Within ninety (90) calendar days of notification from TENNCARE, all vital CONTRACTOR documents shall be translated and available to each Limited English Proficiency group identified by TENNCARE that constitutes five percent (5%) of the TennCare population or one-thousand (1,000) enrollees, whichever is less;
- 2.17.2.6 All written member materials shall notify enrollees that oral interpretation is available for any language at no expense to them and how to access those services;
- 2.17.2.7 All written member materials shall be made available in alternative formats for persons with special needs at no expense to the member;
- 2.17.2.8 The CONTRACTOR shall provide written notice to members of any changes in policies or procedures described in written materials previously sent to members. The CONTRACTOR shall provide written notice at least thirty (30) days before the effective date of the change; and

- 2.17.2.9 The CONTRACTOR shall use the approved glossary of required Spanish terms in the Spanish translation of all member materials.

2.17.3 Distribution of Member Materials

- 2.17.3.1 The CONTRACTOR shall distribute member materials as required by this Agreement. Required materials, described below, include member handbooks, provider directories, quarterly member newsletters, identification cards, and CHOICES member education materials.
- 2.17.3.2 The CONTRACTOR may distribute additional materials and information, other than those required by this Section, Section 2.17, to members in order to promote health and/or educate enrollees.

2.17.4 Member Handbooks

- 2.17.4.1 The CONTRACTOR shall develop a member handbook based on a template provided by TENNCARE, and update it periodically (at least annually). Upon notice to TENNCARE of material changes to the member handbook, the CONTRACTOR shall make appropriate revisions and immediately distribute the revised handbook to members and providers.
- 2.17.4.2 The CONTRACTOR shall distribute member handbooks to members within thirty (30) calendar days of receipt of notice of enrollment in the CONTRACTOR's MCO or prior to enrollees' enrollment effective date as described in Section 2.4.5 and at least annually thereafter. In the event of material revisions to the member handbook, the CONTRACTOR shall distribute the new and revised handbook to all members immediately.
- 2.17.4.3 In situations where there is more than one member in a TennCare case, it shall be acceptable for the CONTRACTOR to mail one (1) member handbook to each address listed for the member's TennCare case number when there is more than one (1) new enrollee assigned to the same case number at the time of enrollment and when subsequent new or updated member handbooks are mailed to members. Should a single individual be enrolled and be added into an existing case, a member handbook (new or updated) shall be mailed to that individual regardless of whether or not a member handbook has been previously mailed to members in the existing case.
- 2.17.4.4 The CONTRACTOR shall distribute a member handbook to all contract providers upon initial credentialing, annually thereafter to all contract providers and the FEA (if and when directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3) as handbooks are updated, and whenever there are material revisions. For purposes of providing member handbooks to providers and to the FEA, it shall be acceptable to provide handbooks in electronic format, including but not limited to CD or access via a web link.
- 2.17.4.5 The CONTRACTOR shall develop a supplement for the member handbook that includes information regarding the CHOICES program. The supplement shall include the information specified in Section 2.17.4.7 that is not currently included in the member handbook, as determined by TENNCARE.

- 2.17.4.5.1 The CONTRACTOR shall distribute the supplement to all existing members, contract providers, and the FEA after TENNCARE has issued member notices regarding CHOICES implementation but prior to the implementation date of CHOICES in the applicable Grand Region covered by this Agreement, to new members in accordance with Section 2.17.4.2 above, and to all contract providers and the FEA in accordance with 2.17.4.4 above. The CONTRACTOR shall distribute the supplement until the member handbook is revised to include the CHOICES program, which shall be no later than the date specified by TENNCARE.
- 2.17.4.6 The CONTRACTOR shall print, disseminate and review with each member in CHOICES Group 2 or 3 participating in consumer direction of HCBS a consumer direction handbook developed by TENNCARE. In the event of material revisions to the consumer direction handbook, the CONTRACTOR shall immediately disseminate and review with each CHOICES member participating in consumer direction key changes as reflected in the new and revised consumer direction handbook.
- 2.17.4.7 Each member handbook shall, at a minimum, be in accordance with the following guidelines:
 - 2.17.4.7.1 Shall be in accordance with all applicable requirements as described in Section 2.17.2 of this Agreement;
 - 2.17.4.7.2 Shall include a table of contents;
 - 2.17.4.7.3 Shall include an explanation on how members will be notified of member specific information such as effective date of enrollment, of PCP assignment, and of care coordinator assignment for CHOICES members;
 - 2.17.4.7.4 Shall include an explanation of how members can request to change PCPs;
 - 2.17.4.7.5 Shall include a description of services provided including benefit limits, the consequences of reaching a benefit limit, non-covered services, and use of non-contract providers, including that members are not entitled to a fair hearing about non-covered services and that members shall use contract providers except in specified circumstances;
 - 2.17.4.7.6 Shall explain that prior authorization is required for some services, including non-emergency services provided by a non-contract provider, and that service authorization is required for all long-term care services; that such services will be covered and reimbursed only if such prior authorization/service authorization is received before the service is provided; that all prior authorizations/service authorizations are null and void upon expiration of a member's TennCare eligibility; and that the member shall be responsible for payment for any services provided after the member's eligibility has expired;

- 2.17.4.7.7 Shall include a statement advising members that the CONTRACTOR may choose to provide certain non-covered services to a particular member when the CONTRACTOR determines that such non-covered services are an appropriate and more cost-effective way of meeting the member's needs than other covered services that would otherwise be provided; a member is not entitled to receive these non-covered services; the decision to provide or not provide these services to a particular member is at the sole discretion of the CONTRACTOR; and if the CONTRACTOR does not provide one of these non-covered services to a member, the member is not entitled to a fair hearing regarding the decision;
- 2.17.4.7.8 Shall include descriptions of the Medicaid Benefits, Standard Benefits, and the covered long-term care services for CHOICES members, by CHOICES group.
- 2.17.4.7.9 Shall include a description of TennCare cost sharing or patient liability responsibilities including an explanation that providers and/or the CONTRACTOR may utilize whatever legal actions are available to collect these amounts. Further, the information shall specify the instances in which a member may be billed for services, and shall indicate that the member may not be billed for covered services except for the amounts of the specified TennCare cost sharing or patient liability responsibilities and explain the member's right to appeal in the event that they are billed for amounts other than their TennCare cost sharing or patient liability responsibilities. The information shall also identify the potential consequences if the member does not pay his/her patient liability, including loss of the member's current nursing facility provider, disenrollment from CHOICES, and, to the extent the member's eligibility depends on receipt of long-term care services, loss of eligibility for TennCare;
- 2.17.4.7.10 Shall include information about preventive services for adults and children, including TENNderCare, a listing of covered preventive services, and notice that preventive services are at no cost and without cost sharing responsibilities;
- 2.17.4.7.11 Shall include procedures for obtaining required services, including procedures for obtaining referrals to specialists as well as procedures for obtaining referrals to non-contract providers. The handbook shall advise members that if they need a service that is not available from a contract provider, they will be referred to a non-contract provider and any copayment requirements would be the same as if this provider were a contract provider;
- 2.17.4.7.12 Shall include information on the CHOICES program, including a description of the CHOICES groups; eligibility for CHOICES; enrollment in CHOICES, including whom to contact at the MCO regarding enrollment in CHOICES; enrollment targets for CHOICES Group 2 and Group 3, including reserve capacity and administration of waiting lists; and CHOICES benefits, including benefit limits, the individual cost neutrality cap for CHOICES Group 2, and the expenditure cap for CHOICES Group 3;
- 2.17.4.7.13 Shall include information on care coordination for CHOICES members, including but not limited to the role of the care coordinator, level of care assessment and reassessment, needs assessment and reassessment, and care planning, including the development of a plan of care for members in CHOICES Groups 2 and 3;

- 2.17.4.7.14 Shall include information on the right of CHOICES members to request an objective review by the State of their needs assessment and/or care planning processes and how to request such a review;
- 2.17.4.7.15 Shall include information regarding consumer direction of HCBS, including but not limited to the roles and responsibilities of the member or the member's representative, the services that can be directed, the member's right to participate in or voluntarily withdraw from consumer direction at any time, the role of and services provided by the FEA, as well as a statement that voluntary or involuntary withdrawal from consumer direction will not affect a member's eligibility for CHOICES;
- 2.17.4.7.16 Shall include an explanation of emergency services and procedures on how to obtain emergency services both in and out of the CONTRACTOR's service area, including but not limited to: an explanation of post-stabilization services, the use of 911, locations of emergency settings and locations for post-stabilization services;
- 2.17.4.7.17 Shall include information on how to access the primary care provider on a twenty-four (24) hour basis as well as the twenty-four (24) hour nurse line. The handbook may encourage members to contact the PCP or twenty-four (24) hour nurse line when they have questions as to whether they should go to the emergency room;
- 2.17.4.7.18 Shall include information on how to access a care coordinator, including the ability to access a care coordinator after regular business hours through the twenty-four (24) hour nurse triage/advice line;
- 2.17.4.7.19 Shall include notice of the right to file a complaint as is provided for by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) and a complaint form on which to do so;
- 2.17.4.7.20 Shall include information about the Long-Term Care Ombudsman Program;
- 2.17.4.7.21 Shall include information about the CHOICES consumer advocate as required by Section 2.29.1.3 of this Agreement, including but not limited to the role of the consumer advocate in the CHOICES program and how to contact the consumer advocate for assistance;
- 2.17.4.7.22 Shall include information about how to report suspected abuse, neglect, and exploitation of members who are adults (see TCA 71-6-101 *et seq.*) and suspected brutality, abuse, or neglect of members who are children (see TCA 37-1-401 *et seq.* and TCA 37-1-601 *et seq.*), including the phone numbers to call to report suspected abuse/neglect;
- 2.17.4.7.23 Shall include complaint and appeal procedures as described in Section 2.19 of this Agreement;
- 2.17.4.7.24 Shall include notice that in addition to the member's right to file an appeal directly to TENNCARE for adverse actions taken by the CONTRACTOR, the member shall have the right to request reassessment of eligibility related decisions directly to TENNCARE;

- 2.17.4.7.25 Shall include written policies on member rights and responsibilities, pursuant to 42 CFR 438.100 and NCQA's Standards and Guidelines for the Accreditation of MCOs;
- 2.17.4.7.26 Shall include written information concerning advance directives as described in 42 CFR 489 Subpart I and in accordance with 42 CFR 422.128;
- 2.17.4.7.27 Shall include notice that enrollment in the CONTRACTOR's MCO invalidates any prior authorization for services granted by another MCO but not utilized by the member prior to the member's enrollment into the CONTRACTOR's MCO and notice of continuation of care when entering the CONTRACTOR's MCO as described in Section 2.9.2 of this Agreement;
- 2.17.4.7.28 Shall include notice to the member that it is the member's responsibility to notify the CONTRACTOR, TENNCARE, and DHS (or for SSI eligibles, SSA) each and every time the member moves to a new address and that failure to notify DHS (or for SSI eligibles, SSA) could result in the member not receiving important eligibility and/or benefit information;
- 2.17.4.7.29 Shall include notice that a new member may request to change MCOs at anytime during the forty-five (45) calendar day period immediately following their initial enrollment in an MCO, subject to the capacity of the selected MCO to accept additional members and any restrictions limiting enrollment levels established by TENNCARE. This notice shall include instructions on how to contact TENNCARE to request a change;
- 2.17.4.7.30 Shall include notice that the member may change MCOs at the next choice period as described in Section 2.4.7.2.2 of this Agreement and shall have a forty-five (45) calendar day period immediately following the enrollment, as requested during said choice period, in a new MCO to request to change MCOs, subject to the capacity of the selected MCO to accept additional enrollees and any restrictions limiting enrollment levels established by TENNCARE. This notice shall include instructions on how to contact TENNCARE to request a change;
- 2.17.4.7.31 Shall include notice that the member has the right to ask TENNCARE to change MCOs based on hardship, the circumstances which constitute hardship, explanation of the member's right to file an appeal if such request is not granted, and how to do so;
- 2.17.4.7.32 Shall include notice of the enrollee's right to terminate participation in the TennCare program at any time with instructions to contact TENNCARE for termination forms and additional information on termination;
- 2.17.4.7.33 Shall include TENNCARE and MCO member services toll-free telephone numbers, including the TENNCARE hotline, the CONTRACTOR's member services information line, and the CONTRACTOR's 24/7 nurse triage/advice line with a statement that the member may contact the CONTRACTOR or TENNCARE regarding questions about the TennCare program, including CHOICES, as well as the service/information that may be obtained from each line;

- 2.17.4.7.34 Shall include information on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free;
- 2.17.4.7.35 Shall include information educating members of their rights and necessary steps to amend their data in accordance with HIPAA regulations and state law;
- 2.17.4.7.36 Shall include directions on how to request and obtain information regarding the “structure and operation of the MCO” and “physician incentive plans” (see Section 2.17.9.2);
- 2.17.4.7.37 Shall include information that the member has the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member’s condition and ability to understand;
- 2.17.4.7.38 Shall include information that the member has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
- 2.17.4.7.39 Shall include information on appropriate prescription drug usage (see Section 2.9.10); and
- 2.17.4.7.40 Shall include any additional information required in accordance with NCQA’s Standards and Guidelines for the Accreditation of MCOs.

2.17.5 Quarterly Member Newsletter

2.17.5.1 General Newsletter

The CONTRACTOR shall, at a minimum, distribute on a quarterly basis a newsletter to all members which is intended to educate the enrollee to the managed care system, proper utilization of services, etc., and encourage utilization of preventive care services.

2.17.5.2 Teen/Adolescent Newsletter

The CONTRACTOR shall, at a minimum, distribute on a quarterly basis a newsletter to all enrollees between the ages of 15 and 20 which is intended to educate the enrollee to the managed care system, proper utilization of services, etc., with an emphasis on the encouragement to utilize TENNderCare services.

2.17.5.2.1 The Teen/Adolescent Newsletter shall be a product of the MCO Adolescent Well-Care Collaborative. The MCOs will agree on five required topics to include in each newsletter. MCOs may include additional articles at their discretion; no deviation from the five agreed upon articles will be allowed unless approved in writing by TENNCARE.

2.17.5.2.1.1 The CONTRACTOR shall include the following information in each newsletter:

2.17.5.2.1.1.1 Five teen/adolescent specific articles as agreed upon by the MCO Adolescent Well Care Collaborative; and

- 2.17.5.2.1.1.2 The procedure on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free; and
- 2.17.5.2.1.1.3 TENNCare information, including but not limited to, encouragement to obtain screenings and other preventive care services.
- 2.17.5.3 The CONTRACTOR shall include the following information in each newsletter:
 - 2.17.5.3.1 Specific articles or other specific information as described when requested by TENNCARE. Such requests by TENNCARE shall be limited to two hundred (200) words and shall be reasonable including sufficient notification of information to be included;
 - 2.17.5.3.2 At least one specific article targeted to CHOICES members;
 - 2.17.5.3.3 Notification regarding the CHOICES program, including a brief description and whom to contact for additional information;
 - 2.17.5.3.4 The procedure on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free;
 - 2.17.5.3.5 A notice to members of the right to file a complaint, as is provided for by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), and a CONTRACTOR phone number for doing so. The notice shall be in English and Spanish;
 - 2.17.5.3.6 TENNCare information, including but not limited to, encouragement to obtain screenings and other preventive care services;
 - 2.17.5.3.7 Information about appropriate prescription drug usage;
 - 2.17.5.3.8 TENNCARE and MCO member services toll-free telephone numbers, including the TENNCARE hotline, the CONTRACTOR's member services information line, and the CONTRACTOR's 24/7 nurse triage/advice line as well as the service/information that may be obtained from each line; and
 - 2.17.5.3.9 The following statement: "To report fraud or abuse to the Office of Inspector General (OIG) you can call toll-free 1-800-433-3982 or go online to www.state.tn.us/tenncare and click on 'Report Fraud'. To report provider fraud or patient abuse to the Medicaid Fraud Control Unit (MFCU), call toll-free 1-800-433-5454."

2.17.5.4 The quarterly member newsletters shall be disseminated within thirty (30) calendar days of the start of each calendar year quarter. In order to satisfy the requirement to distribute the quarterly newsletter to all members, it shall be acceptable to mail one (1) quarterly newsletter to each address associated with the member's TennCare case number. In addition to the prior authorization requirement regarding dissemination of materials to members, the CONTRACTOR shall also submit to TENNCARE, five (5) final printed originals, unless otherwise specified by TENNCARE, of the newsletters and documentation from the MCO's mail room or outside vendor indicating the quantity and date mailed to TennCare as proof of compliance by the 30th of the month following each quarter in accordance with the reporting schedules as described in Section 2.30.1.3 of this Agreement.

2.17.6 Identification Card

Each member shall be provided an identification card, which identifies the member as a participant in the TennCare program within thirty (30) calendar days of notification of enrollment into the CONTRACTOR's MCO or prior to the member's enrollment effective date. The identification card shall be durable (e.g., plastic or other durable paper stock but not regular paper stock), shall comply with all state and federal requirements and, at a minimum, shall include:

- 2.17.6.1 The CONTRACTOR's name and issuer identifier, with the company logo;
- 2.17.6.2 Phone numbers for information and/or authorizations, including for physical health, behavioral health, and long-term care services;
- 2.17.6.3 Descriptions of procedures to be followed for emergency or special services;
- 2.17.6.4 The member's identification number;
- 2.17.6.5 The member's name (First, Last and Middle Initial);
- 2.17.6.6 The member's date of birth;
- 2.17.6.7 The member's enrollment effective date;
- 2.17.6.8 Co-payment information;
- 2.17.6.9 The Health Insurance Portability and Accountability Act (HIPAA) adopted identifier;
- 2.17.6.10 The words "Medicaid" or "Standard" based on eligibility; and
- 2.17.6.11 For CHOICES members, the word "CHOICES."

2.17.7 CHOICES Member Education Materials

2.17.7.1 The CONTRACTOR shall explain and provide member education materials to each CHOICES member (see Section 2.9.6.9.6.4.2).

- 2.17.7.2 The CONTRACTOR shall update and re-print the CHOICES member education materials as specified and with advance notice by TENNCARE. The revised materials shall be submitted to TENNCARE for review and approval. Upon TENNCARE approval, the CONTRACTOR shall immediately distribute the updated materials to all CHOICES members.
- 2.17.7.3 The materials shall comply with all state and federal requirements and, at a minimum, shall include:
 - 2.17.7.3.1 A description of the CHOICES program, including the CHOICES Groups;
 - 2.17.7.3.2 Information on CHOICES groups and the covered long-term care services for each CHOICES group, including HCBS benefit limits for members in CHOICES Group 2 or 3;
 - 2.17.7.3.3 A general description of care coordination and the role of the care coordinator;
 - 2.17.7.3.4 Information about contacting and changing the member's care coordinator, including but not limited to how to contact the care coordinator, how and when the member will be notified of who the assigned care coordinator is, and the procedure for making changes to the assigned care coordinator, whether initiated by the CONTRACTOR or requested by the member;
 - 2.17.7.3.5 Information about the CHOICES consumer advocate (see Section 2.29.1.3), including but not limited to the role of the CHOICES consumer advocate and how to contact the consumer advocate for assistance;
 - 2.17.7.3.6 Information and procedures on how to report suspected abuse and neglect (including abuse, neglect and/or exploitation of members who are adults and suspected brutality, abuse, or neglect of members who are children), including the phone numbers to call to report suspected abuse and neglect;
 - 2.17.7.3.7 Information about estate recovery;
 - 2.17.7.3.8 The procedure on how to obtain member materials in alternative formats for members with special needs and how to access oral interpretation services and that both alternative formats and interpretation services are available at no expense to the member;
 - 2.17.7.3.9 TENNCARE and MCO member services toll-free telephone numbers, including the TENNCARE hotline, the CONTRACTOR's member services information line, and the CONTRACTOR's 24/7 nurse triage/advice line as well as the service/information that may be obtained from each line;
 - 2.17.7.3.10 Information about the member's right to choose between nursing facility and HCBS if the member qualifies for nursing home care and if the member's needs can be safely and effectively met in the community and at a cost that does not exceed the member's cost neutrality cap;
 - 2.17.7.3.11 A description of the care coordinator's role and responsibilities for CHOICES Group 1 members, which at a minimum shall include:

- 2.17.7.3.11.1 Performing needs assessments as deemed necessary by the CONTRACTOR;
- 2.17.7.3.11.2 Participating in the nursing facility's care planning process;
- 2.17.7.3.11.3 Coordinating the member's physical health, behavioral health, and long-term care needs;
- 2.17.7.3.11.4 Conducting face-to-face visits every six (6) months;
- 2.17.7.3.11.5 Conducting level of care reassessments; and
- 2.17.7.3.11.6 Determining the member's interest in transition to the community and facilitating such transition, as appropriate.
- 2.17.7.3.12 Information for CHOICES Group 1 members about patient liability responsibilities including the potential consequences of failure to comply with patient liability requirements, including loss of the member's nursing facility provider, disenrollment from CHOICES, and to the extent that the member's eligibility depends on receipt of long-term care services, loss of eligibility for TennCare;
- 2.17.7.3.13 Information for CHOICES Group 1 members about the CONTRACTOR's nursing facility transition process;
- 2.17.7.3.14 A statement advising members in CHOICES Groups 2 and 3 that the CONTRACTOR may choose to provide certain non-covered services to a particular member when the CONTRACTOR determines that such services are an appropriate and more cost-effective way of meeting the member's needs than other covered services that would otherwise be provided; a member is not entitled to receive these non-covered services; the decision to provide or not provide these non-covered services to a particular member is at the sole discretion of the CONTRACTOR; and if the CONTRACTOR does not provide one of these non-covered services to a member, the member is not entitled to a fair hearing regarding the decision;
- 2.17.7.3.15 A statement advising members in CHOICES Group 2 that the cost of providing HCBS, home health, and private duty nursing shall not exceed the member's cost neutrality cap, and that the cost neutrality cap reflects the projected cost of providing nursing facility services to the member;
- 2.17.7.3.16 A statement advising members in CHOICES Group 3 that the cost of providing HCBS, excluding home modification, to members in CHOICES Group 3 shall not exceed the expenditure cap;
- 2.17.7.3.17 An explanation for members in CHOICES Group 2 of what happens when a member is projected to exceed his/her cost neutrality cap, which shall include the following: The CONTRACTOR will first work with the member to modify the member's plan of care to safely and effectively meet the member's needs in the community and at a cost that is less than the member's cost neutrality cap; if that is not possible, the member will be transitioned to a more appropriate setting (a nursing facility); and if the member declines to move to a more appropriate setting, the member may be

disenrolled from CHOICES, and to the extent that the member's eligibility depends on receipt of long-term care services, may lose eligibility for TennCare;

- 2.17.7.3.18 A statement advising CHOICES members in CHOICES Group 3 that the CONTRACTOR will deny HCBS in excess of the expenditure cap;
- 2.17.7.3.19 A statement advising members that HCBS provided by the CONTRACTOR to CHOICES members will build upon and not supplant a member's existing support system, including but not limited to informal supports provided by family and other caregivers, services that may be available at no cost to the member through other entities, and services that are reimbursable through other public or private funding sources, such as Medicare or long-term care insurance;
- 2.17.7.3.20 A description of the care coordinator's role and responsibilities for CHOICES Group 2 and 3 members, which at a minimum shall include:
 - 2.17.7.3.20.1 Conducting an individualized, comprehensive needs assessment;
 - 2.17.7.3.20.2 Coordinating a care plan team and facilitating the development of a plan of care;
 - 2.17.7.3.20.3 Coordinating the identification of the member's physical health, behavioral health and long-term care needs and coordinating services to meet those needs;
 - 2.17.7.3.20.4 Implementing the authorized plan of care, including ensuring the timely delivery of services in accordance with the plan of care;
 - 2.17.7.3.20.5 Providing assistance in resolving any concerns about service delivery or providers;
 - 2.17.7.3.20.6 Explanation of the minimum contacts a care coordinator is required to make and a statement that the care coordinator may be contacted as often as the member needs to contact the care coordinator;
 - 2.17.7.3.20.7 Completing level of care and needs reassessments and updating the plan of care; and
 - 2.17.7.3.20.8 Ongoing monitoring of service delivery to ensure that any service gaps are immediately addressed and that provided services meet the member's needs;
- 2.17.7.3.21 Information about the right of members in CHOICES Groups 2 and 3 to request an objective review by the State of his/her needs assessment and/or care planning processes and how to make such a request;
- 2.17.7.3.22 Information for members in CHOICES Groups 2 and 3 on consumer direction of HCBS, including but not limited to the roles and responsibilities of the member; the ability of the member to select a representative and who can be a representative; the services that can be directed; the member's right to participate in and voluntarily withdraw from consumer direction at any time; how to choose to participate in consumer direction; the role of the FEA; who can/cannot be hired by the member to perform the services, and when a family member can be paid to provide care and applicable limitations thereto; and

2.17.7.3.23 Information for members in CHOICES Groups 2 and 3 regarding self-direction of health care tasks.

2.17.8 Provider Directories

2.17.8.1 The CONTRACTOR shall distribute general provider directories (see Section 2.17.8.5 below) to new members within thirty (30) calendar days of receipt of notification of enrollment in the CONTRACTOR's MCO or prior to the member's enrollment effective date.

2.17.8.2 The CONTRACTOR shall provide the CHOICES provider directory (see Section 2.17.8.6 below) to each CHOICES member as part of the face-to-face visit (for members enrolled through the SPOE) or face-to-face intake visit (for current members) as applicable, but not more than thirty (30) days from notice of CHOICES enrollment.

2.17.8.3 The CONTRACTOR shall also be responsible for redistribution of updated provider information on a regular basis and shall redistribute a complete and updated general provider directory to all members and an updated CHOICES provider directory to CHOICES members at least on an annual basis. In situations where there is more than one enrollee in a TennCare case, it shall be acceptable for the CONTRACTOR to mail one (1) general provider directory to each address listed for the enrollee's TennCare case number when there is more than one (1) new enrollee assigned to the same case number at the time of enrollment and when subsequent updated provider directories are mailed to enrollees. Should a single individual be enrolled and be added into an existing case, a provider directory shall be mailed to that individual regardless of whether or not a provider directory has been previously mailed to enrollees in the existing case.

2.17.8.4 Provider directories (including both the general provider directory and the CHOICES provider directory), and any revisions thereto, shall be submitted to TENNCARE for written approval prior to distribution to enrollees in accordance with Section 2.17.1 of this Agreement. The text of the directory shall be in the format prescribed by TENNCARE. In addition, the provider information used to populate the provider directory shall be submitted as a TXT file or such format as otherwise approved in writing by TENNCARE and be produced using the same extract process as the actual provider directory.

2.17.8.5 The CONTRACTOR shall develop and maintain a general provider directory, which shall be distributed to all members. The general provider directory shall include the following: names, locations, telephone numbers, office hours, and non-English languages spoken by contract PCPs and specialists; identification of providers accepting new patients; and identification of whether or not a provider performs TENNCare screens; hospital listings, including locations of emergency settings and post-stabilization services, with the name, location, and telephone number of each facility/setting; and a prominent notice that CHOICES members should refer to the CHOICES provider directory for information on long-term care providers.

2.17.8.6 The CONTRACTOR shall develop and maintain a CHOICES provider directory that includes long-term care providers. The CHOICES provider directory, which shall be provided to all CHOICES members, shall include the following: nursing facility listings with the name, location, and telephone number of each facility; community-based residential alternatives, by type, with the name, location, and telephone number of each facility; and a listing of other (non-residential) HCBS providers with the name, location, telephone number, and type of services by county of each provider. Unless and until directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the CHOICES provider directory shall only include information on nursing facility providers. If and when directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the CONTRACTOR shall, as directed by TENNCARE, include in the CHOICES provider directory all information specified in this Section 2.17.8.6.

2.17.9 Additional Information Available Upon Request

The CONTRACTOR shall provide all other information to members as required by CMS, including but not limited to the following information to any enrollee who requests it:

2.17.9.1 Information regarding the structure and operation of the CONTRACTOR's MCO; and

2.17.9.2 Information regarding physician incentive plans, including but not limited to:

2.17.9.2.1 Whether the CONTRACTOR uses a physician incentive plan that affects the use of referral services;

2.17.9.2.2 The type of incentive arrangement; and

2.17.9.2.3 Whether stop-loss protection is provided.

19. Section 2.18 shall be amended by deleting Section 2.18 in its entirety and replacing it with the following and renumbering all references thereto:

2.18 CUSTOMER SERVICE

2.18.1 Member Services Toll-Free Phone Line

2.18.1.1 The CONTRACTOR shall operate a toll-free telephone line (member services information line) to respond to member questions, concerns, inquiries, and complaints from the member, the member's family, or the member's provider.

2.18.1.2 The CONTRACTOR shall develop member services information line policies and procedures that address staffing, training, hours of operation, access and response standards, transfers/referrals, including CHOICES referrals from all sources, monitoring of calls via recording or other means, and compliance with standards.

2.18.1.3 The member services information line shall handle calls from callers with Limited English Proficiency as well as calls from members who are hearing impaired.

- 2.18.1.4 The CONTRACTOR shall ensure that the member services information line is staffed adequately to respond to members' questions, at a minimum, from 8 a.m. to 5 p.m., in the time zone applicable to the Grand Region being served (for the Middle Grand Region, the applicable time zone shall be Central Time), Monday through Friday, except State of Tennessee holidays.
- 2.18.1.5 The member services information line shall be staffed twenty-four (24) hours a day, seven (7) days a week with qualified nurses to triage urgent care and emergency calls from members and to facilitate transfer of calls to a care coordinator from or on behalf of a CHOICES member that require immediate attention by a care coordinator. The CONTRACTOR may meet this requirement by having a separate nurse triage/nurse advice line that otherwise meets all of the requirements of this Section, Section 2.18.1.
- 2.18.1.6 The CONTRACTOR shall ensure that all calls from CHOICES members to the nurse triage/nurse advice line that require immediate attention are immediately addressed or transferred to a care coordinator. During normal business hours, the transfer shall be a "warm transfer" (see definition in Section 1). After normal business hours, if the CONTRACTOR cannot transfer the call as a "warm transfer", the CONTRACTOR shall ensure that a care coordinator is notified and returns the member's call within thirty (30) minutes and that the care coordinator has access to the necessary information (e.g., the member's back-up plan for members in CHOICES Group 2 or 3) to resolve member issues. The CONTRACTOR shall implement protocols, prior approved by TENNCARE, that describe how calls to the nurse triage/nurse advice line from CHOICES members will be handled.
- 2.18.1.7 The member services information line shall be adequately staffed with staff trained to accurately respond to member questions regarding the TennCare program and the CONTRACTOR's MCO, including but not limited to, covered services, the CHOICES program, TENNderCare, and the CONTRACTOR's provider network.
- 2.18.1.8 The CONTRACTOR shall implement protocols, prior approved by TENNCARE, to ensure that calls to the member services information line that should be transferred/referred to other CONTRACTOR staff, including but not limited to a member services supervisor or a care coordinator, or to an external entity, including but not limited to the FEA, are transferred/referred appropriately.
- 2.18.1.9 The CONTRACTOR shall ensure that calls received during normal business hours that require immediate attention by a care coordinator are immediately transferred to a care coordinator as a "warm transfer"; that calls received after normal business hours that require immediate attention are immediately addressed or transferred to a care coordinator in accordance with Section 2.18.1.6; that calls for a member's care coordinator or care coordination team during normal business hours are handled in accordance with Section 2.9.6.11.7; that calls transferred to the FEA during business hours are "warm transfers"; that calls to other CONTRACTOR staff, at a minimum, occur without the caller having to disconnect or place a second call; and that messages to care coordinators and other CONTRACTOR are returned by the next business day.

2.18.1.10 The CONTRACTOR shall measure and monitor the accuracy of responses and phone etiquette and take corrective action as necessary to ensure the accuracy of responses and appropriate phone etiquette by staff.

2.18.1.11 The CONTRACTOR shall have an automated system available during non-business hours, including weekends and holidays. This automated system shall provide callers with operating instructions on what to do in case of an emergency and shall include, at a minimum, a voice mailbox for callers to leave messages. The CONTRACTOR shall ensure that the voice mailbox has adequate capacity to receive all messages. The CONTRACTOR shall return messages on the next business day.

2.18.1.12 Performance Standards for Member Services Line/Queue

2.18.1.12.1 The CONTRACTOR shall adequately staff the member services information line to ensure that the line, including the nurse triage/nurse advice line or queue, meets the following performance standards: less than five percent (5%) call abandonment rate; eighty-five percent (85%) of calls are answered by a live voice within thirty (30) seconds (or the prevailing benchmark established by NCQA); and average wait time for assistance does not exceed ten (10) minutes.

2.18.1.12.2 The CONTRACTOR shall submit the reports required in Section 2.30.12 of this Agreement.

2.18.2 Interpreter and Translation Services

2.18.2.1 The CONTRACTOR shall develop written policies and procedures for the provision of language interpreter and translation services to any member who needs such services, including but not limited to, members with Limited English Proficiency and members who are hearing impaired.

2.18.2.2 The CONTRACTOR shall provide interpreter and translation services free of charge to members.

2.18.2.3 Interpreter services should be available in the form of in-person interpreters, sign language or access to telephonic assistance, such as the ATT universal line.

2.18.3 Cultural Competency

As required by 42 CFR 438.206, the CONTRACTOR shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with Limited English Proficiency and diverse cultural and ethnic backgrounds.

2.18.4 Provider Services and Toll-Free Telephone Line

2.18.4.1 The CONTRACTOR shall establish and maintain a provider services function to timely and adequately respond to provider questions, comments, and inquiries.

2.18.4.2 The CONTRACTOR shall operate a toll-free telephone line (provider service line) to respond to provider questions, comments, and inquiries.

- 2.18.4.3 The CONTRACTOR shall develop provider service line policies and procedures that address staffing, training, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards.
- 2.18.4.4 The CONTRACTOR shall ensure that the provider service line is staffed adequately to respond to providers' questions at a minimum from 8 a.m. to 5 p.m., in the time zone applicable to the Grand Region being served (for the Middle Grand Region, the applicable time zone shall be Central Time), Monday through Friday, except State of Tennessee holidays.
- 2.18.4.5 The provider service line shall also be adequately staffed to provide appropriate and timely responses regarding authorization requests as described in Section 2.14 of this Agreement. The CONTRACTOR may meet this requirement by having a separate utilization management line.
- 2.18.4.6 The provider service line shall be adequately staffed with staff trained to accurately respond to questions regarding the TennCare program and the CONTRACTOR's MCO, including but not limited to, covered services, the CHOICES program, TENNderCare, prior authorization and referral requirements, care coordination, and the CONTRACTOR's provider network. For a period of at least twelve (12) months following the implementation of CHOICES in the Grand Region covered by this Agreement, the CONTRACTOR shall maintain a dedicated queue to assist long-term care providers with enrollment, service authorization, or reimbursement questions or issues. Such period may be extended as determined necessary by TENNCARE.
- 2.18.4.7 For hospitals that have elected to refer patients with non-urgent/emergent conditions to alternative settings for treatment, the CONTRACTOR shall have a specific process in place whereby the Emergency Department (ED) can contact the CONTRACTOR twenty-four (24) hours a day, seven (7) days a week (24/7) via a toll free phone line to obtain assistance for members with non-urgent/emergent conditions who do not require inpatient admission and who are requesting assistance in scheduling an appointment in an alternate treatment setting. The CONTRACTOR may use the 24/7 nurse triage line described in Section 2.18.1.5 of this Agreement for this purpose or may use another line the CONTRACTOR designates. The CONTRACTOR shall submit a description of how it will meet the requirements regarding its 24/7 ED assistance line, which shall provide the telephone number that will be used for hospitals requiring scheduling assistance and describe the process the CONTRACTOR will use to assure all requests are responded to appropriately, including a description of the training provided to staff answering the 24/7 scheduling assistance line. The CONTRACTOR shall track and report the total number of calls received pertaining to patients in ED's needing assistance in accessing care in an alternative setting in accordance with Section 2.30.12.1.3.
- 2.18.4.8 The CONTRACTOR shall measure and monitor the accuracy of responses and phone etiquette and take corrective action as necessary to ensure the accuracy of responses and appropriate phone etiquette by staff.

2.18.4.9 The CONTRACTOR shall have an automated system available during non-business hours. This automated system shall include, at a minimum, a voice mailbox for callers to leave messages. The CONTRACTOR shall ensure that the voice mailbox has adequate capacity to receive all messages. The CONTRACTOR shall return messages on the next business day.

2.18.4.10 Performance Standards for Provider Service Line

2.18.4.10.1 The CONTRACTOR shall adequately staff the provider service line to ensure that the line, including the utilization management line/queue, meets the following performance standards: less than five percent (5%) call abandonment rate; eighty-five percent (85%) of calls are answered by a live voice within thirty (30) seconds (or the prevailing benchmark established by NCQA); and average wait time for assistance does not exceed ten (10) minutes.

2.18.4.10.2 The CONTRACTOR shall submit the reports required in Section 2.30.12 of this Agreement.

2.18.5 Provider Handbook

2.18.5.1 The CONTRACTOR shall issue a provider handbook to all contract providers. The CONTRACTOR may distribute the provider handbook electronically (e.g., via its website) as long as providers are notified about how to obtain the electronic copy and how to request a hard copy at no charge to the provider.

2.18.5.2 The CONTRACTOR shall develop a supplement for the provider handbook regarding CHOICES. This supplement shall include the information in Section 2.18.5.3 relating to the CHOICES program, as determined by TENNCARE, and the supplement shall be prior approved by TENNCARE and TDCI. The CONTRACTOR shall distribute the supplement to all contract providers no later than the end of the quarter prior to implementation of CHOICES in the applicable Grand Region. The CONTRACTOR shall distribute the supplement until the provider handbook is revised to include the CHOICES program, which shall be no later than the date specified by TENNCARE. Unless and until directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the supplement and the provider handbook shall clearly provide that only members in CHOICES Group 1 will be enrolled in TennCare Select.

2.18.5.3 At a minimum the provider handbook shall include the following information:

2.18.5.3.1 Description of the TennCare program;

2.18.5.3.2 Covered services;

2.18.5.3.3 Description of the CHOICES program including but not limited to who qualifies for CHOICES (including the three CHOICES groups and enrollment targets for CHOICES Groups 2 and 3); how to enroll in CHOICES; long-term care services available to each CHOICES Group (including benefit limits, cost neutrality cap for members in CHOICES Group 2, and the expenditure cap for members in CHOICES Group 3); consumer direction of HCBS for members in CHOICES Group 2 or 3; self-direction of health care tasks for members in CHOICES Group 2 or 3

participating in consumer direction of HCBS; the level of care assessment and reassessment process; the needs assessment and reassessment processes; requirement to provide services in accordance with an approved plan of care including the amount, frequency, duration and scope of each service in accordance with the member's service schedule; service authorization requirements and processes; the role of the care coordinator; the role and responsibilities of long-term care and other providers; requirements regarding the electronic visit verification system for HCBS provided to members in CHOICES Group 2 or 3 and the provider's responsibility in monitoring and immediately addressing service gaps for members in CHOICES Group 2 or 3, including back-up staff; how to submit clean claims; and documentation requirements for HCBS providers;

- 2.18.5.3.4 Emergency service responsibilities;
- 2.18.5.3.5 TENNderCare services and standards;
- 2.18.5.3.6 Information on members' appeal rights and complaint processes;
- 2.18.5.3.7 Policies and procedures of the provider complaint system;
- 2.18.5.3.8 Medical necessity standards and clinical practice guidelines;
- 2.18.5.3.9 PCP responsibilities;
- 2.18.5.3.10 Coordination with other TennCare contractors or MCO subcontractors;
- 2.18.5.3.11 Requirements regarding background checks;
- 2.18.5.3.12 Information on identifying and reporting suspected abuse, neglect, and exploitation of members who are adults (see TCA 71-6-101 *et seq.*) and suspected brutality, abuse, or neglect of members who are children (see TCA 37-1-401 *et seq.* and TCA 37-1-601 *et seq.*), including reporting to APS, CPS, and the CONTRACTOR;
- 2.18.5.3.13 Requirements for HCBS providers regarding critical incident reporting and management (see Section 2.15.7);
- 2.18.5.3.14 Requirements for nursing facility providers regarding patient liability (see Sections 2.6.7 and 2.21.5), including the collection of patient liability and the provider's ability, if certain conditions are met (including providing notice and required documentation to the CONTRACTOR and notice to the member), to refuse to provide services if the member does not pay his/her patient liability, as well as the additional potential consequences to the member of non-payment of patient liability, including disenrollment from CHOICES, and, to the extent the member's eligibility depends on receipt of long-term care services, loss of eligibility for TennCare;
- 2.18.5.3.15 Requirement to notify the CONTRACTOR of significant changes in a CHOICES member's condition or care, hospitalizations, or recommendations for additional services (see Section 2.12.9.37);
- 2.18.5.3.16 Prior authorization, referral and other utilization management requirements and procedures;

- 2.18.5.3.17 Protocol for encounter data element reporting/records;
- 2.18.5.3.18 Medical records standard;
- 2.18.5.3.19 Claims submission protocols and standards, including instructions and all information necessary for a clean claim;
- 2.18.5.3.20 Payment policies;
- 2.18.5.3.21 Member rights and responsibilities;
- 2.18.5.3.22 Important phone numbers of all departments/staff a contract provider may need to reach at the CONTRACTOR's MCO; and
- 2.18.5.3.23 How to reach the contract provider's assigned provider relations representative.
- 2.18.5.4 The CONTRACTOR shall disseminate bulletins as needed to incorporate any needed changes to the provider handbook.

2.18.6 Provider Education and Training

- 2.18.6.1 The CONTRACTOR shall develop an education and training plan and materials for contract providers and provide education and training to contract providers and their staff regarding key requirements of this Agreement.
- 2.18.6.2 The CONTRACTOR shall conduct initial education and training to contract providers at least thirty (30) calendar days prior to the start date of operations.
- 2.18.6.3 The CONTRACTOR shall conduct initial education and training for long-term care providers regarding the CHOICES program no later than thirty (30) days prior to implementation of CHOICES in each Grand Region. Unless and until directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 on the date of CHOICES implementation, the CONTRACTOR is only required to provide training to nursing facility providers. When directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the CONTRACTOR shall, as directed by TENNCARE, conduct initial education and training for HCBS providers. This education and training shall include but not be limited to:
 - 2.18.6.3.1 An overview of the CHOICES program;
 - 2.18.6.3.2 The three CHOICES groups and the enrollment targets for each (as applicable);
 - 2.18.6.3.3 The long-term care services available to each CHOICES group (including benefit limits, cost neutrality cap for CHOICES Group 2, and the expenditure cap for CHOICES Group 3);
 - 2.18.6.3.4 The level of care assessment and reassessment processes;
 - 2.18.6.3.5 The needs assessment and reassessment processes;

- 2.18.6.3.6 The CHOICES intake process;
- 2.18.6.3.7 Service authorization requirements and processes;
- 2.18.6.3.8 The role and responsibilities of the care coordinator for members in CHOICES Group 1;
- 2.18.6.3.9 For HCBS providers, the role and responsibilities of the care coordinator for members in CHOICES Groups 2 and 3;
- 2.18.6.3.10 Requirement for HCBS providers to provide services in accordance with an approved plan of care including the amount, frequency, duration and scope of each service in accordance with the member's service schedule;
- 2.18.6.3.11 The role and responsibilities of long-term care and other providers;
- 2.18.6.3.12 Requirements for HCBS providers regarding the electronic visit verification system and the HCBS provider's responsibility in monitoring and immediately addressing service gaps, including back-up staff;
- 2.18.6.3.13 How to submit clean claims;
- 2.18.6.3.14 Background check requirements;
- 2.18.6.3.15 Information about abuse/neglect (which includes abuse, neglect and exploitation of members who are adults and suspected brutality, abuse, or neglect of members who are children), including how to assess risk for abuse/neglect, how to identify abuse/neglect, and how to report abuse/neglect to APS/CPS and the CONTRACTOR;
- 2.18.6.3.16 Critical incident reporting and management for HCBS providers;
- 2.18.6.3.17 The member complaint and appeal processes; and
- 2.18.6.3.18 The provider complaint system.
- 2.18.6.4 The CONTRACTOR shall provide training and education to long-term care providers regarding the CONTRACTOR's enrollment and credentialing requirements and processes (see Section 2.11.8).
- 2.18.6.5 For a period of at least twelve (12) months following the implementation of CHOICES in each Grand Region, the CONTRACTOR shall conduct monthly education and training for long-term care providers regarding claims submission and payment processes, which shall include but not be limited to an explanation of common claims submission errors and how to avoid those errors. Such period may be extended as determined necessary by TENNCARE.

- 2.18.6.6 For a period of at least twelve (12) months following the enrollment of members in CHOICES Group 2 and/or Group 3 (if and when directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3), the CONTRACTOR shall conduct monthly education and training for HCBS providers regarding the use of the EVV system. Such period may be extended as determined necessary by TENNCARE.
- 2.18.6.7 The CONTRACTOR shall provide education and training to HCBS providers on documentation requirements for HCBS.
- 2.18.6.8 The CONTRACTOR shall conduct ongoing provider education, training and technical assistance as deemed necessary by the CONTRACTOR or TENNCARE in order to ensure compliance with this Agreement.
- 2.18.6.9 The CONTRACTOR shall inform all contract PCPs, specialists, and hospitals about the CHOICES program, using a notice developed by TENNCARE, no later than the end of the calendar quarter prior to implementation of the CHOICES program in each Grand Region.
- 2.18.6.10 The CONTRACTOR shall distribute on a quarterly basis a newsletter to contract providers to update providers on CONTRACTOR initiatives and communicate pertinent information to contract providers.
- 2.18.6.11 The CONTRACTOR's provider relations staff shall contact all contract providers on a semi-annual basis to update contract providers on CONTRACTOR initiatives and communicate pertinent information to contract providers. At least one of the two semi-annual contacts made in a year shall be face-to-face with the provider. Semi-annual contacts that are not conducted face-to-face shall be conducted via a phone conversation with the provider. The CONTRACTOR shall maintain records that provide evidence of compliance with the requirement in this Section 2.18.6.11, including when and how contact is made for each contract provider.

2.18.7 **Provider Relations**

- 2.18.7.1 The CONTRACTOR shall establish and maintain a formal provider relations function to provide ongoing troubleshooting and education for contract providers.
- 2.18.7.2 The CONTRACTOR shall provide one-on-one assistance to long-term care providers as needed to help long-term care providers submit clean and accurate claims and minimize claim denial. The CONTRACTOR shall develop and implement protocols, prior approved by TENNCARE, that specify the CONTRACTOR's criteria for providing one-on-one assistance to a provider and the type of assistance the CONTRACTOR will provide. At a minimum, the CONTRACTOR shall contact a provider if, during the first year after implementation of CHOICES in each Grand Region or enrollment of members in CHOICES Group 2 and/or 3 (if and when directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3), the CONTRACTOR has or will deny ten percent (10%) or more of the total value of the provider's claims for a rolling thirty (30) day period, and shall, in addition to issuing a remittance advice, contact the provider to review each of the error(s)/reason(s) for denial and advise how the provider can

correct the error for resubmission (as applicable) and avoid the error/reason for denial in the future.

2.18.7.3 The CONTRACTOR shall implement policies to monitor and ensure compliance of providers with the requirements of this Agreement.

2.18.7.4 The CONTRACTOR shall conduct an annual survey to assess provider satisfaction, including satisfaction with provider enrollment, provider communication, provider education, provider complaints, claims processing, claims reimbursement, care coordination, and utilization management processes, including medical reviews. The CONTRACTOR shall include questions specified by TENNCARE. The CONTRACTOR shall submit an annual report on the survey to TENNCARE as required in Section 2.30.12.4. The CONTRACTOR shall take action to address opportunities for improvement identified through the survey. The survey shall be structured so that behavioral health provider satisfaction results and physical health provider satisfaction results can be separately stratified.

2.18.7.5 The CONTRACTOR shall conduct an annual satisfaction survey of CHOICES long-term care providers that shall include any questions specified by TENNCARE. Instructions specific to the CHOICES survey will be provided by TENNCARE within the first three (3) months of CHOICES implementation. Unless and until directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the CONTRACTOR is only required to survey nursing facility providers. When directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the survey shall include HCBS providers.

2.18.8 Provider Complaint System

2.18.8.1 The CONTRACTOR shall establish and maintain a provider complaint system for any provider (contract or non-contract) who is not satisfied with the CONTRACTOR's policies and procedures or a decision made by the CONTRACTOR that does not impact the provision of services to members.

2.18.8.2 The procedures for resolution of any disputes regarding the payment of claims shall comply with TCA 56-32-126(b) (see Section 2.22.5.2).

2.18.9 FEA Education and Training

The CONTRACTOR shall provide education and training to the FEA and its staff and subcontracted support brokers (as applicable) regarding key requirement in this Agreement and the contract between the CONTRACTOR and the FEA (see Section 2.9.7.3 of this Agreement).

2.18.10 Member Involvement with Behavioral Health Services

2.18.10.1 The CONTRACTOR shall develop policies and procedures with respect to member, parent, or legally appointed representative involvement with behavioral health. These policies and procedures shall include, at a minimum, the following elements:

2.18.10.1.1 The requirement that all behavioral health treatment plans document member involvement. Fulfilling this requirement means that each treatment plan has a

member/family member signature or the signature of a legally appointed representative on the treatment plan and upon each subsequent treatment plan review, where appropriate, and a description of how this requirement will be met;

2.18.10.1.2 The requirement that member education materials include statements regarding the member's, parent's, or legally appointed representative's right to involvement in behavioral health treatment decisions, their ability to choose and change service providers, and a description of how this requirement will be met;

2.18.10.1.3 The requirement that provider education include materials regarding the rights of members, parent(s), or legally appointed representatives to be involved in behavioral health treatment decisions and a description of how this requirement will be met; and

2.18.10.1.4 A description of the quality monitoring activities to be used to measure provider compliance with the requirement for member, parent, or legally appointed representative involvement in behavioral health treatment planning.

2.18.10.2 The CONTRACTOR shall provide an education plan for all members with behavioral health issues; education shall occur on a regular basis. At a minimum, educational materials shall include information on medications and their side effects; behavioral health disorders and treatment options; self-help groups, peer support, and other community support services available for members and families.

2.18.10.3 The CONTRACTOR shall require providers to inform children and adolescents for whom residential treatment is being considered and their parent(s) or legally appointed representative, and adults for whom voluntary inpatient treatment is being considered, of all their options for residential and/or inpatient placement, and alternatives to residential and/or inpatient treatment and the benefits, risks and limitations of each in order that they can provide informed consent.

2.18.10.4 The CONTRACTOR shall require providers to inform all members being considered for prescription of psychotropic medications of the benefits, risks, and side effects of the medication, alternate medications, and other forms of treatment.

20. Section 2.19 shall be amended by deleting Section 2.19 in its entirety and replacing it with the following and renumbering all references thereto:

2.19 COMPLAINTS AND APPEALS

2.19.1 General

2.19.1.1 Members shall have the right to file appeals regarding adverse actions taken by the CONTRACTOR. For purposes of this requirement, appeal shall mean a member's right to contest verbally or in writing, any adverse action taken by the CONTRACTOR to deny, reduce, terminate, delay or suspend a covered service as well as any other acts or omissions of the CONTRACTOR which impair the quality, timeliness, or availability of such benefits. An appeal may be filed by the member or by a person authorized by the member to do so, including but not limited to, a provider or consumer-directed worker with the member's written consent. Complaint shall mean a written or verbal expression of dissatisfaction about an action taken by the CONTRACTOR or service provider other than those that meet the definition of

an adverse action. Examples of complaints include but are not limited to quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider or employee. The CONTRACTOR shall inform members of their complaint and appeal rights in the member handbook in compliance with the requirements in Section 2.17.4. The CONTRACTOR shall have internal complaint and appeal procedures for members in accordance with TennCare rules and regulations, the TennCare waiver, consent decrees, or court orders governing the appeals process.

2.19.1.2 The CONTRACTOR shall devote a portion of its regularly scheduled QM/QI committee meetings, as described in Section 2.15.2, to the review of member complaints and appeals that have been received.

2.19.1.3 The CONTRACTOR shall ensure that punitive action is not taken against a provider or worker who files an appeal on behalf of a member with the member's written consent, supports a member's appeal, or certifies that a member's appeal is an emergency appeal and requires an expedited resolution in accordance with TennCare policies and procedures.

2.19.2 **Complaints**

2.19.2.1 The CONTRACTOR's complaint process shall, at a minimum, meet the requirements outlined herein.

2.19.2.2 The CONTRACTOR's complaint process shall only be for complaints, as defined in Sections 1 and 2.19.1.1 of this Agreement. The CONTRACTOR shall ensure that all appeals, as defined in Sections 1 and 2.19.1.1, are addressed through the appeals process specified in Section 2.19.3 below.

2.19.2.3 The CONTRACTOR shall allow a member to file a complaint either orally or in writing at any time.

2.19.2.4 Within five (5) business days of receipt of the complaint, the CONTRACTOR shall provide written notice to the member that the complaint has been received and the expected date of resolution. However, if the CONTRACTOR resolved the complaint and verbally informed the member of the resolution within five (5) business days of receipt of the complaint, the CONTRACTOR shall not be required to provide written acknowledgement of the complaint.

2.19.2.5 The CONTRACTOR shall resolve and notify the member in writing of the resolution of each complaint as expeditiously as possible but no later than thirty (30) days from the date the complaint is received by the CONTRACTOR. The notice shall include the resolution and the basis for the resolution. However, if the CONTRACTOR resolved the complaint and verbally informed the member of the resolution within five (5) business days of receipt of the complaint, the CONTRACTOR shall not be required to provide written notice of resolution.

2.19.2.6 The CONTRACTOR shall assist members with the complaint process, including but not limited to completing forms.

2.19.2.7 The CONTRACTOR shall track and trend all complaints, timeframes and resolutions and ensure remediation of individual and/or systemic issues.

2.19.2.8 The CONTRACTOR shall submit reports regarding member complaints as specified in Section 2.30.13.

2.19.3 Appeals

2.19.3.1 The CONTRACTOR's appeal process shall, at a minimum, meet the requirements outlined herein.

2.19.3.2 The CONTRACTOR shall have a contact person who is knowledgeable of appeal procedures and shall direct all appeals, whether the appeal is verbal or the member chooses to file in writing, to TENNCARE. Should a member choose to appeal in writing, the member shall be instructed to file via mail or fax to the designated TENNCARE P. O. Box or fax number for medical appeals.

2.19.3.3 The CONTRACTOR shall have sufficient support staff (clerical and professional) available to process appeals in accordance with TennCare requirements related to the appeal of adverse actions affecting a TennCare member. The CONTRACTOR shall notify TENNCARE of the names of appointed staff members and their phone numbers. Staff shall be knowledgeable about applicable state and federal law, TennCare rules and regulations, and all court orders and consent decrees governing appeal procedures, as they become effective.

2.19.3.4 The CONTRACTOR shall educate its staff concerning the importance of the appeals procedure, the rights of the member, and the time frames in which action shall be taken by the CONTRACTOR regarding the handling and disposition of an appeal.

2.19.3.5 The CONTRACTOR shall identify the appropriate individual or body within the CONTRACTOR's MCO having decision-making authority as part of the appeal procedure.

2.19.3.6 The CONTRACTOR shall have the ability to take telephone appeals and accommodate persons with disabilities during the appeals process. Appeal forms shall be available at each service site and by contacting the CONTRACTOR. However, members shall not be required to use a TENNCARE approved appeal form in order to file an appeal.

2.19.3.7 Upon request, the CONTRACTOR shall provide members a TENNCARE approved appeal form(s).

2.19.3.8 The CONTRACTOR shall provide reasonable assistance to all appellants during the appeal process.

2.19.3.9 At any point in the appeal process, TENNCARE shall have the authority to remove a member from the CONTRACTOR's MCO when it is determined that such removal is in the best interest of the member and TENNCARE.

2.19.3.10 The CONTRACTOR shall require providers to display notices of members' right to appeal adverse actions affecting services in public areas of each facility in

accordance with TennCare rules and regulations. The CONTRACTOR shall ensure that providers have correct and adequate supply of public notices.

- 2.19.3.11 Neither the CONTRACTOR nor TENNCARE shall prohibit or discourage any individual from testifying on behalf of a member.
- 2.19.3.12 The CONTRACTOR shall ensure compliance with all notice requirements and notice content requirements specified in applicable state and federal law, TennCare rules and regulations, and all court orders and consent decrees governing notice and appeal procedures, as they become effective.
- 2.19.3.13 TENNCARE may develop additional appeal process guidelines or rules, including requirements as to content and timing of notices to members, which shall be followed by the CONTRACTOR. However, the CONTRACTOR shall not be precluded from challenging any judicial requirements and to the extent judicial requirements that are the basis of such additional guidelines or rules are stayed, reversed or otherwise rendered inapplicable, the CONTRACTOR shall not be required to comply with such guidelines or rules during any period of such inapplicability.
- 2.19.3.14 The CONTRACTOR shall provide general and targeted education to providers regarding expedited appeals (described in TennCare rules and regulations), including when an expedited appeal is appropriate, and procedures for providing written certification thereof.
- 2.19.3.15 The CONTRACTOR shall require providers to provide written certification regarding whether a member's appeal is an emergency upon request by a member prior to filing such appeal, or upon reconsideration of such appeal by the CONTRACTOR when requested by TENNCARE.
- 2.19.3.16 The CONTRACTOR shall provide notice to contract providers regarding provider responsibility in the appeal process, including but not limited to, the provision of medical records and/or documentation as described in Section 2.24.6 and 2.14.8.
- 2.19.3.17 The CONTRACTOR shall urge providers who feel they cannot order a drug on the TennCare Preferred Drug List (PDL) to seek prior authorization in advance, as well as to take the initiative to seek prior authorization or change or cancel the prescription when contacted by a member or pharmacy regarding denial of a pharmacy service due to system edits (e.g., therapeutic duplication, etc.).
- 2.19.3.18 Except for long-term care eligibility and enrollment appeals, which are handled by TENNCARE, member eligibility and eligibility-related grievances and appeals, including termination of eligibility, effective dates of coverage, and the determination of premium, copayment, and patient liability responsibilities shall be directed to the Department of Human Services.

- 21. **Section 2.20.2.2 shall be amended by deleting the reference to "Attachment X" and replacing it with "Attachment VI".**

22. Section 2.21 shall be amended by deleting Section 2.21 in its entirety and replacing it with the following and renumbering all references thereto:

2.21 FINANCIAL MANAGEMENT

The CONTRACTOR shall be responsible for sound financial management of its MCO. The CONTRACTOR shall adhere to the minimum guidelines outlined below.

2.21.1 Administrative Payments

The CONTRACTOR shall accept administrative fee payments, premium tax payments, and incentive payments, if applicable, remitted by TENNCARE in accordance with Section 4.

2.21.2 Savings/Loss

2.21.2.1 The CONTRACTOR shall not be required to share with TENNCARE any financial gains realized under this Agreement.

2.21.2.2 TENNCARE shall not share with the CONTRACTOR any financial losses realized under this Agreement.

2.21.3 Interest

Interest generated from the deposit of funds paid to the CONTRACTOR pursuant to Section 4 of this Agreement shall be the property of the CONTRACTOR and available for use at the CONTRACTOR's discretion. See Section 2.13.22 regarding interest generated from the deposit of funds for provider payments.

2.21.4 Third Party Liability Resources

2.21.4.1 The TennCare program shall be the payer of last resort for all covered services in accordance with federal regulations. The CONTRACTOR shall exercise full assignment rights as applicable and shall be responsible for making every reasonable effort to determine the liability of third parties to pay for services rendered to enrollees under this Agreement and cost avoid and/or recover any such liability from the third party. The CONTRACTOR shall develop and implement policies and procedures to meet its obligations regarding third party liability when the third party (e.g., long-term care insurance) pays a cash benefit to the member, regardless of services used or does not allow the member to assign his/her benefits.

2.21.4.1.1 If third party liability (TPL) exists for part or all of the services provided directly by the CONTRACTOR to an enrollee, the CONTRACTOR shall make reasonable efforts to recover from TPL sources the value of services rendered.

2.21.4.1.2 If TPL exists for part or all of the services provided to an enrollee by a subcontractor or a provider, and the third party will make payment within a reasonable time, the CONTRACTOR may pay the subcontractor or provider only the amount, if any, by which the subcontractor's or provider's allowable claim exceeds the amount of TPL.

- 2.21.4.1.3 If the probable existence of TPL has been established at the time the claim is filed, the CONTRACTOR may reject the claim and return it to the provider for a determination of the amount of any TPL, unless the claim is for one of these services:
 - 2.21.4.1.3.1 TENNderCare;
 - 2.21.4.1.3.2 Prenatal or preventive pediatric care; or
 - 2.21.4.1.3.3 All claims covered by absent parent maintained insurance under Part D of Title IV of the Social Security Act.
- 2.21.4.1.4 The claims specified in Sections 2.21.4.1.3.1, 2.21.4.1.3.2, and 2.21.4.1.3.3 shall be paid at the time presented for payment by the provider and the CONTRACTOR shall bill the responsible third party.
- 2.21.4.2 The CONTRACTOR shall deny payment on a claim that has been denied by a third party payer when the reason for denial is the provider or enrollee's failure to follow prescribed procedures, including but not limited to, failure to obtain prior authorization, timely filing, etc.
- 2.21.4.3 The CONTRACTOR shall treat funds recovered from third parties as offsets to claims payments. The CONTRACTOR shall report all cost avoidance values to TENNCARE in accordance with federal guidelines and as described in Section 2.21.4 of this Agreement.
- 2.21.4.4 The CONTRACTOR shall post all third party payments to claim level detail by enrollee.
- 2.21.4.5 Third party resources shall include subrogation recoveries. The CONTRACTOR shall be required to seek subrogation amounts regardless of the amount believed to be available as required by federal Medicaid guidelines. The amount of any subrogation recoveries collected by the CONTRACTOR outside of the claims processing system shall be the property of the State.
- 2.21.4.6 The CONTRACTOR shall conduct diagnosis and trauma code editing to identify potential subrogation claims. This editing should, at minimum, identify claims with a diagnosis of 900.00 through 999.99 (excluding 994.6) or claims submitted with an accident trauma indicator of 'Y.'
- 2.21.4.7 TennCare cost sharing and patient liability responsibilities permitted pursuant to Sections 2.6.7 and 2.21.5 of this Agreement shall not be considered TPL.
- 2.21.4.8 The CONTRACTOR shall provide TPL data to any provider having a claim denied by the CONTRACTOR based upon TPL.
- 2.21.4.9 The CONTRACTOR shall provide to TENNCARE any third party resource information necessary in a format and media described by TENNCARE and shall cooperate in any manner necessary, as requested by TENNCARE, with TENNCARE and/or a cost recovery vendor at such time that TENNCARE acquires said services.

- 2.21.4.10 TENNCARE may require a TennCare contracted TPL vendor to review paid claims that are over ninety (90) calendar days old and pursue TPL (excluding subrogation) for those claims that do not indicate recovery amounts in the CONTRACTOR's reported encounter data.
- 2.21.4.11 If the CONTRACTOR operates or administers any non-Medicaid HMO, health plan or other lines of business, the CONTRACTOR shall assist TENNCARE with the identification of enrollees with access to other insurance.
- 2.21.4.12 The CONTRACTOR shall demonstrate, upon request, to TENNCARE that reasonable effort has been made to seek, collect and/or report third party recoveries. TENNCARE shall have the sole responsibility for determining whether reasonable efforts have been demonstrated. Said determination shall take into account reasonable industry standards and practices.
- 2.21.4.13 TENNCARE shall be solely responsible for estate recovery activities and shall retain any and all funds recovered through these activities.

2.21.5 Patient Liability

- 2.21.5.1 TENNCARE will notify the CONTRACTOR of any applicable patient liability amounts for members via the eligibility/enrollment file.
- 2.21.5.2 The CONTRACTOR shall delegate collection of patient liability to the nursing facility or community-based residential alternative facility and shall pay the facility net of the applicable patient liability amount. For members in CHOICES Groups 2 or 3 receiving non-residential HCBS, the CONTRACTOR shall collect applicable patient liability amounts.

2.21.6 Solvency Requirements

2.21.6.1 Minimum Net Worth

- 2.21.6.1.1 The CONTRACTOR shall establish and maintain the minimum net worth requirements required by TDCI, including but not limited to TCA 56-32-112.
- 2.21.6.1.2 Any and all payments made by TENNCARE, including administrative fee payments, as well as incentive payments (if applicable) to the CONTRACTOR shall be considered "Premium revenue" for the purpose of calculating the minimum net worth required by TCA 56-32-112.
- 2.21.6.1.3 The CONTRACTOR shall demonstrate evidence of its compliance with this provision to TDCI in the financial reports filed with TDCI by the CONTRACTOR.

2.21.6.2 Restricted Deposits

The CONTRACTOR shall achieve and maintain restricted deposits in an amount equal to the net worth requirement specified in Section 2.21.6.1. TDCI shall calculate the amount of restricted deposits based on the CONTRACTOR's TennCare premium revenue only unless this calculation would result in restricted deposits below the statutory requirements set forth in TCA 56-32-112 related to restricted deposits; in which case the required amount would be equal to the statutory requirement as it is calculated by TDCI. This contractual requirement shall in no way be construed as a way to circumvent, waive or modify the statutory requirement.

2.21.6.3 Liquidity Ratio Requirement

In addition to the positive working capital requirement described in TCA 56-32-112, the CONTRACTOR shall maintain a liquidity ratio where admitted assets consisting of cash, cash equivalents, short-term investments and bonds exceed total liabilities as reported on the NAIC financial statements.

2.21.6.4 If the CONTRACTOR fails to meet and/or maintain the applicable net worth and/or restricted deposit financial requirements in accordance with Sections 2.21.6.1 through 2.21.6.3, as determined by TDCI, the CONTRACTOR agrees that said failure shall constitute hazardous financial conditions as defined by TCA 56-32-112 and the CONTRACTOR shall be considered to be in breach of the terms of the Agreement.

2.21.7 **Accounting Requirements**

2.21.7.1 The CONTRACTOR shall establish and maintain an accounting system in accordance with generally accepted accounting principles. The accounting system shall maintain records pertaining to the tasks defined in this Agreement and any other costs and expenditures made under the Agreement.

2.21.7.2 Specific accounting records and procedures are subject to TENNCARE and federal approval. Accounting procedures, policies, and records shall be completely open to state and federal personnel at any time during the Agreement period and for five (5) years thereafter unless otherwise specified elsewhere in this Agreement.

2.21.8 **Insurance**

2.21.8.1 The CONTRACTOR shall obtain adequate worker's compensation and general liability insurance coverage prior to commencing any work in connection with this Agreement. Additionally, TENNCARE may require, at its sole discretion, the CONTRACTOR to obtain adequate professional malpractice liability or other forms of insurance. Any insurance required by TENNCARE shall be in the form and substance acceptable to TENNCARE.

2.21.8.2 Except as otherwise provided in Section 2.12 or in the model contract with the FEA, the CONTRACTOR shall require that any subcontractors or contract providers obtain all similar insurance required of it prior to commencing work.

- 2.21.8.3 The CONTRACTOR shall furnish proof of adequate coverage of insurance by a certificate of insurance submitted to TENNCARE.
- 2.21.8.4 TENNCARE shall be exempt from and in no way liable for any sums of money that may represent a deductible in any insurance policy. The payment of such a deductible shall be the sole responsibility of the CONTRACTOR, subcontractor and/or provider obtaining such insurance. The same holds true of any premiums paid on any insurance policy pursuant to this Agreement.
- 2.21.8.5 Failure to provide proof of adequate coverage within the specified time period may result in this Agreement being terminated.

2.21.9 Ownership and Financial Disclosure

The CONTRACTOR shall disclose, to TENNCARE, the Comptroller General of the United States or CMS, full and complete information regarding ownership, financial transactions and persons convicted of criminal activity related to Medicare, Medicaid, or the federal Title XX programs in accordance with federal and state requirements, including Public Chapter 379 of the Acts of 1999. The CONTRACTOR shall screen their employees and contractors initially and on an ongoing monthly basis to determine whether any of them has been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded. This disclosure shall be made in accordance with the requirements in Section 2.30.15.2.2. The following information shall be disclosed:

- 2.21.9.1 The name and address of each person with an ownership or control interest in the disclosing entity or in any provider or subcontractor in which the disclosing entity has direct or indirect ownership of five percent (5%) or more and whether any of the persons named pursuant to this requirement is related to another as spouse, parent, child, or sibling. This disclosure shall include the name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest;
- 2.21.9.2 The identity of any provider or subcontractor with whom the CONTRACTOR has had significant business transactions, defined as those totaling more than twenty-five thousand dollars (\$25,000) during the twelve (12) month period ending on the date of the disclosure, and any significant business transactions between the CONTRACTOR, any wholly owned supplier, or between the CONTRACTOR and any provider or subcontractor, during the five (5) year period ending on the date of the disclosure;
- 2.21.9.3 The identity of any person who has an ownership or control interest in the CONTRACTOR, or is an agent or managing employee of the CONTRACTOR and who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the federal Title XX services program since the inception of those programs;
- 2.21.9.4 Disclosure from officials in legislative and executive branches of government as to possible conflicts of interest;

- 2.21.9.5 If the CONTRACTOR is not a federally qualified HMO, the CONTRACTOR shall disclose certain transactions with parties in interest to TENNCARE. Transactions shall be reported according to the following guidelines:
 - 2.21.9.5.1 The CONTRACTOR shall disclose the following transactions:
 - 2.21.9.5.1.1 Any sale, exchange or lease of any property between the HMO and a party in interest;
 - 2.21.9.5.1.2 Any lending of money or other extension of credit between the HMO and a party in interest; and
 - 2.21.9.5.1.3 Any furnishing for consideration of goods, services (including management services) or facilities between the HMO and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.
 - 2.21.9.5.2 The information which shall be disclosed in the transactions includes:
 - 2.21.9.5.2.1 The name of the party in interest for each transaction;
 - 2.21.9.5.2.2 A description of each transaction and the quantity or units involved;
 - 2.21.9.5.2.3 The accrued dollar value of each transaction during the fiscal year; and
 - 2.21.9.5.2.4 Justification of the reasonableness of each transaction.
 - 2.21.9.5.3 If the Agreement is being renewed or extended, the CONTRACTOR shall disclose information on business transactions which occurred during the prior contract period. If the Agreement is an initial Agreement with TENNCARE, but the CONTRACTOR has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period shall be disclosed. The business transactions which shall be reported are not limited to transactions related to serving the Medicaid/TennCare enrollment. All of the CONTRACTOR's business transactions shall be reported.
 - 2.21.9.5.4 A party in interest is:
 - 2.21.9.5.4.1 Any director, officer, partner, or employee responsible for management or administration of an HMO and HIO; any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of the HMO; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than five percent (5%) of the HMO; or, in the case of an HMO organized as a nonprofit corporation, an incorporator or member of such corporation under applicable state corporation law;
 - 2.21.9.5.4.2 Any organization in which a person described in subsection 1 is director, officer or partner; has directly or indirectly a beneficial interest of more than five percent (5%) of the equity of the HMO; or has a mortgage, deed of trust, note, or other interest valuing more than five percent (5%) of the assets of the HMO;

- 2.21.9.5.4.3 Any person directly or indirectly controlling, controlled by, or under common control with an HMO; or
- 2.21.9.5.4.4 Any spouse, child, or parent of an individual described in Sections 2.21.9.5.4.1, 2.21.9.5.4.2, or 2.21.9.5.4.3
- 2.21.9.5.5 TENNCARE and/or the Secretary of Health and Human Services may request information to be in the form of a consolidated financial statement.

2.21.10 Internal Audit Function

The CONTRACTOR shall establish and maintain an internal audit function responsible for providing an independent review and evaluation of the CONTRACTOR's accuracy of financial recordkeeping, the reliability and integrity of information, the adequacy of internal controls, and compliance with applicable laws, policies, procedures, and regulations. The CONTRACTOR's internal audit function shall be responsible for performing audits to ensure the economical and efficient use of resources by all departments to accomplish the objectives and goals for the operations of the department. Further, the CONTRACTOR's internal audit department shall be responsible for performance of the claims payment accuracy tests as described in Section 2.22.6 of this Agreement.

2.21.11 Audit of Business Transactions

- 2.21.11.1 The CONTRACTOR shall cause an audit of its business transactions to be performed by a licensed certified public accountant, including but not limited to the financial transactions made under this Agreement. Such audit shall be performed in accordance with the requirements in Section 2.30.15.3.5 of this Agreement.
- 2.21.11.2 No later than December 1 of each year, the CONTRACTOR shall submit a copy of the full executed agreement to audit accounts to TENNCARE. Such agreement shall include the following language:
 - 2.21.11.2.1 The auditor agrees to retain working papers for no less than five (5) years and that all audit working papers shall, upon request, be made available for review by the Comptroller of the Treasury, the Comptroller's representatives, agents, and legal counsel, or the TennCare Division of the Tennessee Department of Commerce and Insurance, during normal working hours while the audit is in progress and/or subsequent to the completion of the report. Nothing in this Section shall be construed to modify or change the obligations of the CONTRACTOR contained in Section 2.23.2 (Data and Document Management Requirements), 2.23.3 (System and Data Integration Requirements), or 2.23.6 (Security and Access Management Requirements) of this Agreement.
 - 2.21.11.2.2 Any evidence of fraud, such as defalcation, misappropriation, misfeasance, malfeasance, embezzlement, fraud or other illegal acts shall be reported by the auditor, in writing immediately upon discovery, to the Comptroller of the Treasury, State of Tennessee, who shall under all circumstances have the authority, at the discretion of the Comptroller, to directly investigate such matters. If the circumstances disclosed by the audit call for a more detailed investigation by the auditor than necessary under ordinary circumstances, the auditor shall inform the organization's governing body in writing of the need for such additional investigation

and the additional compensation required therefore. Upon approval by the Comptroller of the Treasury, an amendment to this contract may be made by the organization's governing body and the auditor for such additional investigation.

23. Section 2.22 shall be amended by deleting Section 2.22 in its entirety and replacing it with the following and renumbering all references thereto:

2.22 CLAIMS MANAGEMENT

2.22.1 General

To the extent that the CONTRACTOR compensates providers on a fee-for-service or other basis requiring the submission of claims as a condition of payment, the CONTRACTOR shall process, as described herein, the provider's claims for covered benefits provided to members consistent with applicable CONTRACTOR policies and procedures and the terms of this Agreement including but not limited to timely filing, and compliance with all applicable state and federal laws, rules and regulations.

2.22.2 Claims Management System Capabilities

2.22.2.1 The CONTRACTOR shall maintain a claims management system that can uniquely identify the provider of the service, date of receipt (the date the CONTRACTOR receives the claim as indicated by a date-stamp), real-time-accurate history of actions taken on each provider claim (i.e., paid, denied, suspended, appealed, etc.), date of payment (the date of the check or other form of payment) and all data elements as required by TENNCARE for encounter data submission (see Section 2.23), and can track and report service use against benefit limits in accordance with a methodology set by TENNCARE.

2.22.2.2 The CONTRACTOR shall have in place, an electronic claims management (ECM) capability that can handle online submission of individual claims by long-term care providers as well as accept and process batches of claims submitted electronically with the exception of claims that require written documentation to justify payment (e.g., hysterectomy/sterilization consent forms, certification for medical necessity for abortion, necessary operative reports, etc.). The online claims submission capability for long-term care providers shall be accessible via the World Wide Web or through an alternate, functionally equivalent medium.

2.22.2.3 The ECM capability shall function in accordance with information exchange and data management requirements specified in Section 2.23 of this Agreement.

2.22.2.4 As part of the ECM function, the CONTRACTOR shall also provide on-line and phone-based capabilities to obtain claims processing status information.

2.22.2.5 The CONTRACTOR shall support an automated clearinghouse (ACH) mechanism that allows providers to request and receive electronic funds transfer (EFT) of claims payments.

2.22.2.6 The CONTRACTOR shall not derive financial gain from a provider's use of electronic claims filing functionality and/or services offered by the CONTRACTOR

or a third party. However, this provision shall not be construed to imply that providers may not be responsible for payment of applicable transaction fees/charges.

2.22.3 Paper Based Claims Formats

2.22.3.1 The CONTRACTOR shall comply at all times with standardized paper billing forms/formats (and all future updates) as follows:

Claim Type	Claim Form
Professional	CMS 1500
Institutional	CMS 1450/UB04
Dental	ADA

2.22.3.2 The CONTRACTOR shall not revise or modify the standardized forms or format.

2.22.3.3 For the forms identified in Section 2.22.3.1, the CONTRACTOR shall adhere to national standards and standardized instructions and definitions that are consistent with industry norms that are developed jointly with TENNCARE. These shall include, but not be limited to, HIPAA-based standards, federally required safeguard requirements including signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR 455.18 and 455.19, as well as TDCI rules for Uniform Claims Process for TennCare in accordance with TCA 71-5-191.

2.22.3.4 The CONTRACTOR agrees that at such time that TENNCARE in conjunction with appropriate work groups presents recommendations concerning claims billing and processing that are consistent with industry norms, the CONTRACTOR shall comply with said recommendations within ninety (90) calendar days from notice by TENNCARE.

2.22.4 Prompt Payment

2.22.4.1 The CONTRACTOR shall comply with prompt pay claims processing requirements in accordance with TCA 56-32-126.

2.22.4.2 The CONTRACTOR shall ensure that ninety percent (90%) of clean claims for payment for services delivered to a TennCare enrollee are paid within thirty (30) calendar days of the receipt of such claims.

2.22.4.3 The CONTRACTOR shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all claims for covered services delivered to a TennCare enrollee. The terms “processed and paid” are synonymous with terms “process and pay” of TCA 56-32-126(b)(1)(A) and (B).

2.22.4.4 Notwithstanding Sections 2.22.4.1 through 2.22.4.3, the CONTRACTOR shall comply with the following processing requirements for nursing facility claims and for HCBS claims for services other than PERS, assistive technology, minor home modifications, and pest control submitted electronically in a HIPAA-compliant format:

- 2.22.4.4.1 Ninety percent (90%) of clean claims for nursing facility services and HCBS excluding PERS, assistive technology, minor home modifications, and pest control shall be processed and paid within fourteen (14) calendar days of receipt.
- 2.22.4.4.2 Ninety-nine point five percent (99.5%) of clean claims for nursing facility services and HCBS other than PERS, assistive technology, minor home modifications, and pest control shall be processed and paid within twenty-one (21) calendar days of receipt.
- 2.22.4.5 The CONTRACTOR shall comply with the requirements in Sections 2.22.4.2 and 2.22.4.3 above for processing claims for PERS, assistive technology, minor home modifications, and pest control.
- 2.22.4.6 The CONTRACTOR shall provide claims information and supporting claims documentation as specified by TENNCARE or TDCI in order for TENNCARE and/or TDCI to verify the CONTRACTOR's compliance with prompt payment requirements.
- 2.22.4.7 If a claim is partially or totally denied on the basis the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written or electronic notice shall specifically identify all such information and documentation. Resubmission of a claim with further information and/or documentation shall constitute a new claim for purposes of establishing the time frame for claims processing.
- 2.22.4.8 To the extent that the provider agreement requires compensation of a provider on a monthly fixed fee basis or on any other basis that does not require the submission of a claim as a condition to payment, such payment shall be made to the provider by no later than (i) the time period specified in the provider agreement/contract between the provider and the CONTRACTOR or subcontractor, or if a time period is not specified in the contract (ii) the tenth (10th) day of the calendar month if the payment is to be made by a subcontractor, or (iii) if the CONTRACTOR is required to compensate the provider directly, within five (5) calendar days after receipt of the capitated payment and supporting remittance advice information from TENNCARE.
- 2.22.4.9 The CONTRACTOR shall not deny provider claims on the basis of untimely filing in situations regarding coordination of benefits or subrogation, in which case the provider is pursuing payment from a third party or if an enrollee is enrolled in the CONTRACTOR's MCO with a retroactive eligibility date. In situations of third party benefits, the time frames for filing a claim shall begin on the date that the third party documented resolution of the claim. In situations of enrollment in the CONTRACTOR's MCO with a retroactive eligibility date, the time frames for filing a claim shall begin on the date that the CONTRACTOR receives notification from TENNCARE of the enrollee's eligibility/enrollment.
- 2.22.4.10 As it relates to MCO Assignment Unknown (see Sections 2.13.11 and 2.13.12), the CONTRACTOR shall not deny a claim on the basis of the provider's failure to file a claim within a specified time period after the date of service when the provider could not have reasonably known which MCO the member was in during the timely filing period. However, in such cases the CONTRACTOR may impose timely filing requirements beginning on the date of notification of the individual's enrollment.

2.22.5 Claims Dispute Management

- 2.22.5.1 The CONTRACTOR shall have an internal claims dispute procedure that will be reviewed and approved in writing by TENNCARE prior to its implementation.
- 2.22.5.2 The CONTRACTOR shall contract with independent reviewers to review disputed claims as provided by TCA 56-32-126.
- 2.22.5.3 The CONTRACTOR shall systematically capture the status and resolution of all claim disputes, as well as all associated documentation.

2.22.6 Claims Payment Accuracy – Minimum Audit Procedures

- 2.22.6.1 On a monthly basis the CONTRACTOR shall submit claims payment accuracy percentage reports (see Section 2.30.16.1).
- 2.22.6.2 The report shall be based on an audit conducted by the CONTRACTOR. The audit shall be conducted by an entity or staff independent of claims management. Requirements for the internal audit function are outlined in Section 2.21.10 of this Agreement.
- 2.22.6.3 The audit shall utilize a random sample of all “processed or paid” claims upon initial submission in each month (the terms “processed and paid” are synonymous with terms “process and pay” of TCA 56-32-126(b)(1)(A) and (B)). A minimum sample of one hundred and sixty (160) claims randomly selected from the entire population of electronic and paper claims processed or paid upon initial submission for the month tested is required. Additionally, each monthly sample of one hundred and sixty (160) claims shall contain a minimum of thirty (30) claims associated with nursing facility services provided to CHOICES members and thirty (30) claims associated with HCBS provided to CHOICES members. Until members in CHOICES Group 2 and/or 3 are enrolled in TennCare Select (if and when directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3), each monthly sample shall only include nursing facility claims.
- 2.22.6.4 The minimum attributes to be tested for each claim selected shall include:
 - 2.22.6.4.1 Claim data correctly entered into the claims processing system;
 - 2.22.6.4.2 Claim is associated to the correct provider, or if submitted by the FEA, the correct consumer-directed worker;
 - 2.22.6.4.3 Service obtained the proper authorization;
 - 2.22.6.4.4 Member eligibility at processing date correctly applied;
 - 2.22.6.4.5 Allowed payment amount agrees with contracted rate;
 - 2.22.6.4.6 Duplicate payment of the same claim has not occurred;
 - 2.22.6.4.7 Denial reason applied appropriately;

- 2.22.6.4.8 Copayment application considered and applied;
- 2.22.6.4.9 Patient liability correctly identified and applied;
- 2.22.6.4.10 Effect of modifier codes correctly applied;
- 2.22.6.4.11 Other insurance, including long-term care insurance, properly considered and applied;
- 2.22.6.4.12 Application of benefit limits;
- 2.22.6.4.13 Whether the processing of the claim correctly considered whether services that exceeded a benefit limit for HCBS were provided as a cost effective alternative;
- 2.22.6.4.14 Application of the cost neutrality cap for a member in CHOICES Group 2;
- 2.22.6.4.15 Application of the expenditure cap for a member in CHOICES Group 3; and
- 2.22.6.4.16 Proper coding including bundling/unbundling.
- 2.22.6.5 For audit and verification purposes, the population of claims should be maintained. Additionally, the results of testing at a minimum should be documented to include:
 - 2.22.6.5.1 Results for each attribute tested for each claim selected;
 - 2.22.6.5.2 Amount of overpayment or underpayment for claims processed or paid in error;
 - 2.22.6.5.3 Explanation of the erroneous processing for each claim processed or paid in error;
 - 2.22.6.5.4 Determination if the error is the result of keying errors or the result of errors in the configuration or table maintenance of the claims processing system; and
 - 2.22.6.5.5 Claims processed or paid in error have been corrected.
- 2.22.6.6 If the CONTRACTOR subcontracts for the provision of any covered services (see Section 2.26), and the subcontractor is responsible for processing claims (see Section 2.26.12), then the CONTRACTOR shall submit a claims payment accuracy percentage report for the claims processed by the subcontractor. The report shall be based on an audit conducted in compliance with the requirements of this Section 2.22.6.

2.22.7 Claims Processing Methodology Requirements

- 2.22.7.1 The CONTRACTOR shall perform front end system edits, including but not limited to:
 - 2.22.7.1.1 Confirming eligibility on each enrollee as claims are submitted on the basis of the eligibility information provided by the State that applies to the period during which the charges were incurred;

- 2.22.7.1.2 Third party liability (TPL);
- 2.22.7.1.3 Medical necessity (e.g., appropriate age/sex for procedure);
- 2.22.7.1.4 Prior approval: the system shall determine whether a covered service required prior approval and, if so, whether the CONTRACTOR granted such approval;
- 2.22.7.1.5 Duplicate claims: the system shall in an automated manner flag a claim as being (1) exactly the same as a previously submitted claim or (2) a possible duplicate and either deny or pend the claim as needed;
- 2.22.7.1.6 Covered service: the system shall verify that a service is a covered service and is eligible for payment;
- 2.22.7.1.7 Provider validation: the system shall approve for payment only those claims received from providers eligible to render services for which the claim was submitted; and
- 2.22.7.1.8 Benefit limits: the system shall ensure that benefit limit rules set by TENNCARE are factored into the determination of whether a claim should be adjudicated and paid and whether HCBS that exceed a benefit limit were approved as a cost effective alternative.
- 2.22.7.2 The CONTRACTOR shall perform system edits for valid dates of service: the system shall assure that dates of service are valid dates, e.g., date of discharge is later than date of admission; admission or discharge dates are not in the future or outside of a member's TennCare eligibility span.
- 2.22.7.3 The CONTRACTOR shall ensure that the cost neutrality cap or expenditure cap applicable to a particular CHOICES member is not exceeded.
- 2.22.7.4 The CONTRACTOR shall perform post-payment review on a sample of claims to ensure services provided were medically necessary and were provided in accordance with state and federal requirements. This shall include, as applicable, review of provider documentation.
- 2.22.7.5 The CONTRACTOR shall have a staff of qualified, medically trained and appropriately licensed personnel, consistent with NCQA accreditation standards, whose primary duties are to assist in evaluating claims for medical necessity.
- 2.22.8 **Explanation of Benefits (EOBs) and Related Functions**
 - 2.22.8.1 The CONTRACTOR shall be responsible for generating and mailing EOBs to TennCare enrollees in accordance with guidelines described by TENNCARE.
 - 2.22.8.2 The CONTRACTOR shall omit any claims in the EOB file that are associated with sensitive services. The CONTRACTOR, with guidance from TENNCARE, shall develop "sensitive services" logic to be applied to the handling of said claims for EOB purposes.
 - 2.22.8.3 At a minimum, EOBs shall be designed to address requirements found in 42 CFR 455.20 and 433.116 as well as requirements associated with a change in TennCare

policy and shall include: claims for services with benefit limits, claims with enrollee cost sharing, denied claims with enrollee responsibility, and a sampling of paid claims (excluding ancillary and anesthesia services).

- 2.22.8.4 On a monthly basis, the CONTRACTOR shall sample a minimum of one hundred (100) claims and associated EOBs. The sample shall be based on a minimum of twenty-five (25) claims per check run. The EOBs shall be examined for correctness based on how the associated claim was processed and for adherence to the requirements outlined in Section 2.22.7. The CONTRACTOR shall ensure that the examined EOBs constitute a representative sample of EOBs from all types of services and provider types. To the extent that the CONTRACTOR and/or TENNCARE considers a particular type of service or provider to warrant closer scrutiny, the CONTRACTOR shall over sample as needed.
- 2.22.8.5 Based on the EOBs sent to TennCare enrollees, the CONTRACTOR shall track any complaints received from enrollees and resolve the complaints according to its established policies and procedures. The resolution may be enrollee education, provider education, or referral to TBI/OIG. The CONTRACTOR shall use the feedback received to modify or enhance the EOB sampling methodology.

2.22.9 Remittance Advices and Related Functions

- 2.22.9.1 In concert with its claims payment cycle the CONTRACTOR shall provide an electronic status report indicating the disposition for every adjudicated claim for each claim type submitted by providers seeking payment as well as capitated payments generated and paid by the CONTRACTOR.
- 2.22.9.2 The status report shall contain appropriate explanatory remarks related to payment or denial of the claim, including but not limited to TPL data.
- 2.22.9.3 If a claim is partially or totally denied on the basis the provider did not submit any required information or documentation with the claim, then the remittance advice shall specifically identify all such information and documentation.
- 2.22.9.4 In accordance with 42 CFR 455.18 and 455.19, the following statement shall be included on each remittance advice sent to providers: "I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents, or concealment of a material fact, may be prosecuted under applicable federal and/or state laws."

2.22.10 Processing of Payment Errors

The CONTRACTOR shall not employ off-system or gross adjustments when processing corrections to payment errors, unless it requests and receives prior written authorization from TENNCARE.

2.22.11 Notification to Providers

For purposes of network management, the CONTRACTOR shall, at a minimum, notify all contract providers to file claims associated with covered services directly with the CONTRACTOR, or its subcontractors, on behalf of TennCare enrollees.

2.22.12 Payment Cycle

At a minimum, the CONTRACTOR shall run one (1) provider payment cycle per week, on the same day each week, as determined by the CONTRACTOR and approved in writing by TENNCARE.

2.22.13 Excluded Providers

2.22.13.1 The CONTRACTOR shall not pay any claim submitted by a provider who is excluded from participation in Medicare, Medicaid, or SCHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act or is otherwise not in good standing with TENNCARE.

2.22.13.2 The CONTRACTOR shall not pay any claim submitted by a provider that is on payment hold under the authority of TENNCARE.

24. Section 2.23.1.6 shall be deleted in its entirety and replaced with the following:

2.23.1.6 Systems Refresh Plan

The CONTRACTOR shall provide to TENNCARE an annual *Systems Refresh Plan* (see Section 2.30.17). The plan shall outline how Systems within the CONTRACTOR's span of control will be systematically assessed to determine the need to modify, upgrade and/or replace application software, operating hardware and software, telecommunications capabilities, information management policies and procedures, and/or systems management policies and procedures in response to changes in business requirements, technology obsolescence, staff turnover and other relevant factors. The systems refresh plan shall also indicate how the CONTRACTOR will insure that the version and/or release level of all of its Systems components (application software, operating hardware, operating software) are always formally supported by the original equipment manufacturer (OEM), software development firm (SDF), or a third party authorized by the OEM and/or SDF to support the System component.

25. Section 2.23.2 shall be amended by adding a new Sub-Section 2.23.2.1 and renumbering the existing Sub-Sections accordingly including all references thereto. The new Sub-Section 2.23.2.1 shall read as follows:

2.23.2.1 HIPAA and HITECH

The parties warrant that they are familiar with the Federal regulations under HIPAA and HITECH and agree to comply with the provisions as amended and to the extent the following apply: "Individually Identifiable Health Information," "Protected Health Information," "Unsecured PHI," "Safeguarding Enrollee Information," and "Privacy Breach".

26. Section 2.23.4.3.7 shall be deleted in its entirety and replaced with the following:

2.23.4.3.7 The CONTRACTOR shall institute processes to insure the validity and completeness of the data it submits to TENNCARE. At its discretion, TENNCARE will conduct general data validity and completeness audits using industry-accepted statistical sampling methods. Data elements that will be audited include but are not limited to: member ID, date of service, provider ID (including NPI number and Medicaid I.D. Number), category and sub category (if applicable) of service, diagnosis codes, procedure codes and modifiers, revenue codes, adherence to benefit limits, date of claim processing, and date of claim payment. Control totals shall also be reviewed and verified. Additionally, the CONTRACTOR shall reconcile all encounter data submitted to the State to control totals and to the CONTRACTOR's Medical Fund Target reports and supply the reconciliation to TENNCARE with each of the Medical Fund Target report submissions as specified in Section 2.30.15.2.1.

27. Section 2.24 shall be amended by deleting Section 2.24 in its entirety and replacing it with the following and renumbering all references thereto:

2.24 ADMINISTRATIVE REQUIREMENTS

2.24.1 General Responsibilities

2.24.1.1 TENNCARE shall be responsible for management of this Agreement. Management shall be conducted in good faith with the best interest of the State and the citizens it serves being the prime consideration. Management of TennCare shall be conducted in a manner consistent with simplicity of administration and the best interests of enrollees, as required by 42 USC 1396a(a)(19).

2.24.1.2 The CONTRACTOR shall be responsible for complying with the requirements of this Agreement and shall act in good faith in the performance of the requirements of this Agreement.

2.24.1.3 The CONTRACTOR shall develop policies and procedures that describe, in detail, how the CONTRACTOR will comply with the requirements of this Agreement and, as applicable, are specific to each Grand Region covered by this Agreement, and the CONTRACTOR shall administer this Agreement in accordance with those policies and procedures unless otherwise directed or approved in writing by TENNCARE.

2.24.1.4 It is recognized that TennCare Select medical management procedures may differ from the CONTRACTOR's medical management procedures utilized for operations under the "TennCare Contractor Risk Agreement" in order to recognize the unique populations served by this Agreement. To the extent that TennCare Select medical management procedures are different from the CONTRACTOR's "TennCare Contractor Risk Agreement" medical management procedures, the CONTRACTOR shall obtain written approval from TENNCARE unless otherwise directed or approved by TENNCARE.

2.24.1.5 The CONTRACTOR shall submit policies and procedures and other deliverables specified by TENNCARE to TENNCARE for review and/or written approval in the

format and within the time frames specified by TENNCARE. The CONTRACTOR shall make any changes requested by TENNCARE to policies and procedures or other deliverables and in the time frames specified by TENNCARE.

- 2.24.1.6 As provided in Section 5.10 of this Agreement, should the CONTRACTOR have a question on policy determinations, benefits, or operating guidelines required for proper performance of the CONTRACTOR's responsibilities, the CONTRACTOR shall request a determination from TENNCARE in writing.

2.24.2 Behavioral Health Advisory Committee

The CONTRACTOR shall establish a behavioral health advisory committee that is accountable to the CONTRACTOR's governing body to provide input and advice regarding all aspects of the provision of behavioral health services according to the following requirements:

- 2.24.2.1 The CONTRACTOR's behavioral health advisory committee shall be comprised of at least fifty-one percent (51%) consumer and family representatives, of which the majority shall include families of adults with serious and/or persistent mental illness (SPMI) and families of children with serious emotional disturbance (SED);
- 2.24.2.2 There shall be geographic diversity;
- 2.24.2.3 There shall be cultural and racial diversity;
- 2.24.2.4 There shall be representation by providers and consumers (or family members of consumers) of substance abuse services;
- 2.24.2.5 At a minimum, the CONTRACTOR's behavioral health advisory committee shall have input into policy development, planning for services, service evaluation, and member, family member and provider education;
- 2.24.2.6 Meetings shall be held at least quarterly;
- 2.24.2.7 Travel costs shall be paid by the CONTRACTOR;
- 2.24.2.8 The CONTRACTOR shall report on the activities of the CONTRACTOR's behavioral health advisory committee as required in Section 2.30.18.1; and
- 2.24.2.9 The CONTRACTOR, as membership changes, shall submit current membership lists to the State.

2.24.3 CHOICES Advisory Group

- 2.24.3.1 To promote a collaborative effort to enhance the long-term care service delivery system in each Grand Region covered by this Agreement while maintaining a member-centered focus, the CONTRACTOR shall establish a CHOICES advisory group that is accountable to the CONTRACTOR's governing body to provide input and advice regarding the CONTRACTOR's CHOICES program and policies. Unless and until directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the requirements of Section 2.24.3 do not apply. When directed by TENNCARE to serve as a back-up health plan and/or enroll

members in CHOICES Group 2 and/or 3, the CONTRACTOR shall, as directed by TENNCARE, comply with the requirements of Section 2.24.3.

- 2.24.3.2 The CONTRACTOR's CHOICES advisory group shall include CHOICES members, member's representatives, advocates, and providers. At least fifty-one percent (51%) of the group shall be CHOICES members and/or their representatives (e.g., family members or caregivers). The advisory group shall include representatives from nursing facility and HCBS providers, including community-based residential alternative providers. The group shall reflect the geographic, cultural and racial diversity of each Grand Region covered by this Agreement.
- 2.24.3.3 At a minimum, the CONTRACTOR's CHOICES advisory group shall have input into the CONTRACTOR's planning and delivery of long-term care services, CHOICES QM/QI activities, program monitoring and evaluation, and member, family and provider education.
- 2.24.3.4 The CONTRACTOR shall provide an orientation and ongoing training for advisory group members so they have sufficient information and understanding of the CHOICES program to fulfill their responsibilities.
- 2.24.3.5 The CONTRACTOR's CHOICES advisory group shall meet at least quarterly, and the CONTRACTOR shall keep a written record of meetings.
- 2.24.3.6 The CONTRACTOR shall pay travel costs for advisory group members who are CHOICES members or their representatives.
- 2.24.3.7 The CONTRACTOR shall report on the activities of the CONTRACTOR's CHOICES advisory group as required in Section 2.30.18.2.
- 2.24.3.8 As advisory group membership changes, the CONTRACTOR shall submit current membership lists to TENNCARE.

2.24.4 **Abuse and Neglect Plan**

- 2.24.4.1 The CONTRACTOR shall develop and implement an abuse and neglect plan that includes protocols for preventing, identifying, and reporting suspected abuse, neglect, and exploitation of CHOICES members who are adults (see TCA 71-6-101 *et seq.*) and suspected brutality, abuse, or neglect of CHOICES members who are children (see TCA 37-1-401 *et seq.* and TCA 37-1-601 *et seq.*); a plan for educating and training providers, subcontractors, care coordinators, and other CONTRACTOR staff regarding the protocols; and a plan for training members, representatives, and caregivers regarding identification and reporting of suspected abuse and/or neglect.
- 2.24.4.2 The CONTRACTOR's abuse and neglect protocols shall include, but not be limited to the following:
 - 2.24.4.2.1 Protocols for assessing risk for abuse and/or neglect, including factors that may indicate the potential for abuse and/or neglect;
 - 2.24.4.2.2 Protocols for reducing a member's risk of abuse and/or neglect (e.g., frequency of care coordinator home visits, referrals to non-covered support services);

- 2.24.4.2.3 Indicators for identifying suspected abuse and/or neglect;
- 2.24.4.2.4 Requirements for reporting suspected abuse and/or neglect, including reporting suspected abuse and/or neglect of a child pursuant to TCA 37-1-403, reporting suspected abuse and/or neglect of an adult to APS pursuant to TCA 71-6-103, and reporting suspected abuse and/or neglect to the CONTRACTOR pursuant to Section 2.15.7.4;
- 2.24.4.2.5 Steps for protecting a member if abuse and/or neglect is suspected (e.g., removing a staff person suspected of committing the abuse and/or neglect, making referrals for members to support services); and
- 2.24.4.2.6 Requirements regarding coordination and cooperation with APS/CPS investigations and remediations.
- 2.24.4.3 If and when directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the CONTRACTOR's abuse and neglect plan shall also define the role and responsibilities of the fiscal employer agent (see definition in Section 1) in assessing and reducing a member's risk of abuse and neglect, identifying and reporting abuse and neglect, protecting a member if abuse and/or neglect is suspected; training employees, contractors of the FEA (including supports brokers), and consumer-directed workers regarding the protocols identified in Sections 2.24.4.2.1 through 2.24.4.2.6 above; and training members and caregivers regarding identification and reporting of suspected abuse and/or neglect. Such role and responsibilities shall be defined in a manner that is consistent with requirements in this Section 2.24.4 as well as TENNCARE's contract with the fiscal employer agent and the model contract between the CONTRACTOR and the FEA.

2.24.5 **Performance Standards**

The CONTRACTOR agrees TENNCARE may assess liquidated damages for failure to meet the performance standards specified in Attachment VII. Unless and until directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the performance standards in Attachment VII applicable only to CHOICES Group 2 and/or 3, as determined by TENNCARE, will not apply. When directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, all of the performance standards in Attachment VII shall apply.

2.24.6 **Medical Records Requirements**

- 2.24.6.1 The CONTRACTOR shall maintain, and shall require contract providers and subcontractors to maintain, medical records (as defined in Section 1) in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review, administrative, civil and/or criminal investigations and/or prosecutions.
- 2.24.6.2 The CONTRACTOR shall have medical record keeping policies and practices which are consistent with 42 CFR Part 456 and current NCQA standards for medical record documentation. The CONTRACTOR shall distribute these policies to practice sites. At a minimum, the policies and procedures shall address:

- 2.24.6.2.1 Confidentiality of medical records;
- 2.24.6.2.2 Medical record documentation standards; and
- 2.24.6.2.3 The medical record keeping system and standards for the availability of medical records. At a minimum the following shall apply:
 - 2.24.6.2.3.1 As applicable, medical records shall be maintained or available at the site where covered services are rendered;
 - 2.24.6.2.3.2 Enrollees (for purposes of behavioral health records, enrollee includes an individual who is age sixteen (16) or over) and their legally appointed representatives shall be given access to the enrollees' medical records, to the extent and in the manner provided by TCA 63-2-101, 63-2-102 and 33-3-104 *et seq.*, and, subject to reasonable charges, (except as provided in Section 2.24.6.2.3.3 below) be given copies thereof upon request;
 - 2.24.6.2.3.3 Provisions for ensuring that, in the event a patient-provider relationship with a TennCare primary care provider ends and the enrollee requests that medical records be sent to a second TennCare provider who will be the enrollee's primary care provider, the first provider does not charge the enrollee or the second provider for providing the medical records; and
 - 2.24.6.2.3.4 Performance goals to assess the quality of medical record keeping.
- 2.24.6.2.4 The CONTRACTOR shall maintain and require contract behavioral health providers to maintain medical records in conformity with TCA 33-3-101 *et seq.* for persons with serious emotional disturbance or mental illness.
- 2.24.6.2.5 The CONTRACTOR shall maintain and require contract behavioral health providers to maintain medical records of persons whose confidentiality is protected by 42 CFR Part 2 in conformity with that rule or TCA 33-3-103, whichever is more stringent.

2.24.7 **Location of Non-Responsive TennCare Eligibles**

The CONTRACTOR agrees to attempt to locate "non-responsive TennCare eligibles" that have been enrolled in the CONTRACTOR's MCO. Non-responsive TennCare eligibles are persons identified by TENNCARE who have not responded to re-verification attempts and who have not (and whose family members have not) accessed services during the period of review. Within 90 days of identification, the CONTRACTOR shall attempt to reach each non-responsive TennCare eligible identified by TENNCARE to the CONTRACTOR and assigned to TennCare Select effective July 1, 2001. The CONTRACTOR shall attempt to reach each non-responsive TennCare eligible telephonically using the phone number provided by TENNCARE. Upon placement of the call, if the CONTRACTOR receives a message that the phone number has been changed, the CONTRACTOR shall update the enrollee's phone number in its system and make at least three documented attempts to contact said enrollee at the new number to obtain the enrollee's new address. If successful, the CONTRACTOR will forward this information to TENNCARE via the Weekly Enrollee Information Report as well as a Non-Responsive File via CD Rom which shall include additional data elements as described in this Section. If TENNCARE does not provide a telephone number, the CONTRACTOR shall make and document at least one attempt to contact

the non-responsive TennCare eligible through other publicly available information resources. In addition, the CONTRACTOR shall monitor claims activity for non-responsive TennCare eligibles. In the event the CONTRACTOR receives a claim for payment on behalf of a non-responsive TennCare eligible, the CONTRACTOR shall contact the provider and request the enrollee's phone number and address on file with the provider. The CONTRACTOR shall make at least three documented attempts to contact the enrollee at the location provided by the provider to confirm the enrollee's address. Once confirmed, the CONTRACTOR shall forward this information to TENNCARE via the Weekly Enrollee Information Report as well as a Non-Responsive File via CD Rom which shall include additional data elements as described in this Section. The CONTRACTOR shall complete this process within 45 days for other non-responsive TennCare eligible as they are identified by TENNCARE to the CONTRACTOR.

- 28. Section 2.25 shall be amended by adding a new Sub-Section 2.25.9 and renumbering the existing Sub-Sections accordingly, including any references thereto. The new Sub-Section 2.25.9 shall read as follows:**

2.25.9 CHOICES Consumer/Family Surveys

The EQRO will administer an annual survey to a representative sample of CHOICES members to assess members' quality of life and members' and/or caregivers' satisfaction with the CHOICES program. The CONTRACTOR shall cooperate fully with the EQRO in conducting the survey. The EQRO will provide a copy of its findings to the CONTRACTOR.

- 29. Section 2.25 shall be amended by adding a new Sub-Section 2.25.10 and renumbering the existing Sub-Sections accordingly, including any references thereto. The new Sub-Section 2.25.10 shall read as follows:**

2.25.10 Monitoring Quality of Care for CHOICES

In addition to any other monitoring activities conducted by TENNCARE, the CONTRACTOR shall cooperate fully with any monitoring activities conducted by TENNCARE regarding the CHOICES program. These activities will include but not be limited to the following:

2.25.10.1 Quarterly and annual monitoring to ensure that CHOICES members receive appropriate disease management interventions and the adequacy and appropriateness of these interventions based on stratification and setting (see Section 2.30.5).

2.25.10.2 Quality of care activities will be monitored through information obtained in a quarterly *CHOICES Care Coordination Report* (see Section 2.30.6.7) and through activities performed by the Quality Oversight Division of TennCare. These activities may include monitoring and technical assistance through site visits to the CONTRACTOR, chart audits, phone calls, etc. TENNCARE may validate the *CHOICES Care Coordination* report and may conduct a more in-depth review and/or request additional information for instances where the CONTRACTOR does not adhere to required timeframes. TENNCARE may require a corrective action plan and/or impose sanctions to address non-compliance issues and to improve CONTRACTOR performance.

2.25.10.3 Quarterly monitoring to determine the CONTRACTOR's adherence to the requirements in this Agreement regarding processes for identifying, assessing, and

transitioning CHOICES who may have the ability and/or desire to transition from a nursing facility to the community. TENNCARE will review the *CHOICES Nursing Facility to Community Transition* reports submitted by the CONTRACTOR (see Section 2.30.6.4) to determine the CONTRACTOR's performance on specified measures. TENNCARE may validate the report and may conduct a more in-depth review and/or request additional information. TENNCARE may require a corrective action plan and/or impose sanctions to address non-compliance issues and to improve CONTRACTOR performance.

- 2.25.10.4 Monthly monitoring regarding missed and late visits. TENNCARE will review the *CHOICES HCBS Late and Missed Visits* reports submitted by the CONTRACTOR (see Section 2.30.6.5) to determine the CONTRACTOR's performance on specified measures. TENNCARE may validate the report and may conduct a more in-depth review and/or request additional information. TENNCARE may require a corrective action plan and/or impose sanctions to address non-compliance issues and to improve CONTRACTOR performance.
- 2.25.10.5 Periodic case reviews will be conducted at the discretion of TENNCARE in order to assess the CONTRACTOR's needs assessment and care planning processes.
- 2.25.10.6 Quarterly monitoring of the CONTRACTOR's provider network file (see Section 2.30.7) to ensure that CHOICES provider network requirements are met (see Section 2.11.6).
- 2.25.10.7 Annual monitoring of the CONTRACTOR's long-term care provider network development plan to ensure that the CONTRACTOR is making sufficient progress towards meeting its network development and expansion goals (see Section 2.11.6.6). TENNCARE will review the plan provided by the CONTRACTOR (see Section 2.30.7.6) and will evaluate the adequacy of the CONTRACTOR's long-term care network and the CONTRACTOR's efforts to improve the network where deficiencies exist.
- 2.25.10.8 Quarterly monitoring of critical incidents. TENNCARE will review the *CHOICES HCBS Critical Incidents* reports submitted by the CONTRACTOR (see Section 2.30.11.6) to identify potential performance improvement activities. TENNCARE may conduct a more in-depth review and/or request additional information.
- 2.25.10.9 Quarterly monitoring of the CONTRACTOR's member complaints process to determine compliance with timeframes prescribed in Section 2.19.2 of this Agreement and appropriateness of resolutions. TENNCARE will review the *Member Complaints* reports submitted by the CONTRACTOR (see Section 2.30.13), to determine the CONTRACTOR's performance on specified measures. TENNCARE may validate the report and may conduct a more in-depth review and/or request additional information. TENNCARE may require a corrective action plan and/or impose sanctions to address non-compliance issues and to improve CONTRACTOR performance.
- 2.25.10.10 Review of all reports from the CONTRACTOR (see Section 2.30) and any related follow-up activities.

30. Section 2.26 shall be amended by deleting Section 2.26 in its entirety and replacing it with the following and renumbering all references thereto:

2.26 SUBCONTRACTS

2.26.1 Subcontract Relationships and Delegation

If the CONTRACTOR delegates responsibilities to a subcontractor, the CONTRACTOR shall ensure that the subcontracting relationship and subcontracting document(s) comply with federal requirements, including, but not limited to, compliance with the applicable provisions of 42 CFR 438.230(b) and 42 CFR 434.6 as described below:

2.26.1.1 The CONTRACTOR shall evaluate the prospective subcontractor's ability to perform the activities to be delegated;

2.26.1.2 The CONTRACTOR shall require that the agreement be in writing and specify the activities and report responsibilities delegated to the subcontractor and provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate;

2.26.1.3 The CONTRACTOR shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review, on at least an annual basis, consistent with NCQA standards and state MCO laws and regulations;

2.26.1.4 The CONTRACTOR shall identify deficiencies or areas for improvement, and the CONTRACTOR and the subcontractor shall take corrective action as necessary; and

2.26.1.5 If the subcontract is for purposes of providing or securing the provision of covered services to enrollees, the CONTRACTOR shall ensure that all requirements described in Section 2.12 of this Agreement are included in the subcontract and/or a separate provider agreement executed by the appropriate parties.

2.26.2 Legal Responsibility

The CONTRACTOR shall be responsible for the administration and management of all aspects of this Agreement including all subcontracts/subcontractors. The CONTRACTOR shall ensure that the subcontractor shall not enter into any subsequent agreements or subcontracts for any of the work contemplated under the subcontractor for purposes of this Agreement without prior written approval of the CONTRACTOR. No subcontract, provider agreement or other delegation of responsibility terminates or reduces the legal responsibility of the CONTRACTOR to TENNCARE to ensure that all activities under this Agreement are carried out in compliance with the Agreement.

2.26.3 Prior Approval

All subcontracts, as defined in Section 1 of this Agreement, and revisions thereto shall be approved in advance in writing by TENNCARE. The CONTRACTOR shall revise subcontracts as directed by TENNCARE. Approval of subcontracts shall not be considered granted unless TENNCARE issues its approval in writing. Once a subcontract has been executed by all of the participating parties, a copy of the fully executed subcontract shall be sent to TENNCARE within thirty (30) calendar days of execution. This written prior approval requirement does not relieve

the CONTRACTOR of any responsibilities to submit all proposed material modifications of the CONTRACTOR's MCO operations to TDCI for prior review and approval as required by Title 56, Chapter 32, Part 1.

2.26.4 Subcontracts for Behavioral Health Services

If the CONTRACTOR subcontracts for the provision or management of behavioral health services, the subcontract shall be specific to the TennCare program, and the CONTRACTOR shall comply with the requirements in Section 2.6.1.2 regarding integration of physical health and behavioral health services.

2.26.5 Subcontracts for Assessments and Plans of Care

If the CONTRACTOR subcontracts with an entity specifically to conduct care coordination functions, including level of care or needs assessments or reassessments and/or developing or authorizing plans of care (see Section 2.9.6), such subcontractor shall not provide any direct long-term care services. This does not preclude nursing facilities or hospitals contracted with the CONTRACTOR to deliver services from completing and submitting pre-admission evaluations.

2.26.6 Contract with Fiscal Employer Agent (FEA)

As required in Section 2.9.7.3, the CONTRACTOR shall contract with TENNCARE's designated FEA to provide assistance to members choosing consumer direction of HCBS. The CONTRACTOR shall not be liable for any failure, error, or omission by the FEA related to the FEA's verification of worker qualification.

2.26.7 Standards

The CONTRACTOR shall require and ensure that the subcontractor complies with all applicable requirements in this Agreement. This includes, but is not limited to, Sections 2.19, 2.21.7, 2.25.5, 2.25.6, 2.25.8, 2.25.9, 5.3, 5.19, 5.31, and 5.32 of this Agreement.

2.26.8 Quality of Care

If the subcontract is for the purpose of securing the provision of covered services, the subcontract shall specify that the subcontractor adhere to the quality requirements the CONTRACTOR is held to.

2.26.9 Interpretation/Translation Services and Limited English Proficiency (LEP) Provisions

The CONTRACTOR shall provide instruction for all direct service subcontractors regarding the CONTRACTOR's written procedure for the provision of language interpretation and translation services for any member who needs such services, including but not limited to, enrollees with Limited English Proficiency.

2.26.10 Children in State Custody

The CONTRACTOR shall include in its subcontracts a provision stating that subcontractors are not permitted to encourage or suggest, in any way, that TennCare children be placed into State custody in order to receive medical or behavioral health services covered by TENNCARE.

2.26.11 Assignability

Transportation and claims processing subcontracts shall include language requiring that the subcontract agreement shall be assignable from the CONTRACTOR to the State, or its designee: i) at the State's discretion upon written notice to the CONTRACTOR and the affected subcontractor; or ii) upon CONTRACTOR's request and written approval by the State. Further, the subcontract agreement shall include language by which the subcontractor agrees to be bound by any such assignment, and that the State, or its designee, shall not be responsible for past obligations of the CONTRACTOR.

2.26.12 Claims Processing

2.26.12.1 All claims for services furnished to a TennCare enrollee filed with a CONTRACTOR shall be processed by either the CONTRACTOR or by one (1) subcontractor retained by the organization for the purpose of processing claims. However, another entity can process claims related to behavioral health, vision, lab, or transportation if that entity has been retained by the CONTRACTOR to arrange and provide for the delivery of said services. However, all claims processed by any subcontractor shall be maintained and submitted by the CONTRACTOR.

2.26.12.2 As required in Section 2.30.19 of this Agreement, where the CONTRACTOR has subcontracted claims processing for TennCare claims, the CONTRACTOR shall provide to TENNCARE a Type II examination based on the Statement on Auditing Standards (SAS) No. 70, Service Organizations.

2.26.13 HIPAA Requirements

The CONTRACTOR shall require all its subcontractors to adhere to HIPAA requirements.

2.26.14 Compensation for Utilization Management Activities

Should the CONTRACTOR have a subcontract arrangement for utilization management activities, the CONTRACTOR shall ensure, consistent with 42 CFR 438.210(e) that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee, as provided by the Balanced Budget Act of 1997 and the provisions of 42 CFR 438.210(e).

2.26.15 Notice of Subcontractor Termination

2.26.15.1 When a subcontract that relates to the provision of services to enrollees or claims processing services is being terminated, the CONTRACTOR shall give at least thirty (30) calendar days prior written notice of the termination to TENNCARE and TDCI.

2.26.15.2 TENNCARE reserves the right to require this notice requirement and procedures for other subcontracts if determined necessary upon review of the subcontract for approval.

31. Section 2.28 shall be amended by deleting Section 2.28 in its entirety and replacing it with the following and renumbering all references thereto:

2.28 NON-DISCRIMINATION COMPLIANCE REQUIREMENTS

- 2.28.1 The CONTRACTOR shall comply with Section 5.32 of this Agreement regarding non-discrimination, proof of non-discrimination, and notices of non-discrimination.
- 2.28.2 In order to demonstrate compliance with federal and state regulations of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), the Church Amendments (42 U.S.C. 300a-7), Section 245 of the Public Health Service Act (42 U.S.C. 238n.), and the Weldon Amendment (Consolidated Appropriations Act 2008, Public Law 110-161, Div. G, Sec. 508 (d), 121 Stat. 1844, 2209), the CONTRACTOR shall designate a staff person to be responsible for non-discrimination compliance as required in Section 2.29.1. This person shall provide instruction to all CONTRACTOR staff, providers and direct service subcontractors regarding the CONTRACTOR's non-discrimination policies and procedures and all applicable non-discrimination compliance requirements of the TennCare program. The CONTRACTOR shall be able to show documented proof of such instruction.
- 2.28.3 The CONTRACTOR shall develop written policies and procedures that demonstrate non-discrimination in the provision of services to members. The policy shall also demonstrate non-discrimination in the provision of services for members with Limited English Proficiency and those requiring communication assistance in alternative formats (see Section 2.18.2). These policies and procedures shall be prior approved in writing by TENNCARE.
- 2.28.4 The CONTRACTOR shall, at a minimum, emphasize non-discrimination in its personnel policies and procedures as it relates to hiring, promoting, operational policies, contracting processes and participation on advisory/planning boards or committees.
- 2.28.5 The CONTRACTOR shall ask all staff to provide their race or ethnic origin and sex. The CONTRACTOR is required to request this information from all CONTRACTOR staff. CONTRACTOR staff response is voluntary. The CONTRACTOR is prohibited from utilizing information obtained pursuant to such a request as a basis for decisions regarding employment or in determination of compensation amounts.
- 2.28.6 The CONTRACTOR shall ask all providers for their race or ethnic origin. Provider response is voluntary. The CONTRACTOR is prohibited from utilizing information obtained pursuant to such a request as a basis for decision regarding participation in the CONTRACTOR's provider network or in determination of compensation amounts.
- 2.28.7 The CONTRACTOR shall track and investigate all complaints alleging discrimination filed by employees, enrollees, providers and subcontractors related to the provision of and access to TennCare covered services provided by the CONTRACTOR. The CONTRACTOR shall track and investigate all complaints alleging discrimination filed by employees (when the complaint is related to the TennCare program), enrollees, providers and subcontractors in which discrimination is alleged in the CONTRACTOR's TennCare MCO. The CONTRACTOR shall track, at a minimum, the following elements: identity of the party filing the complaint; the complainant's relationship to the CONTRACTOR; the circumstances of the complaint; date

complaint filed; CONTRACTOR's resolution, if resolved; and name of CONTRACTOR staff person responsible for adjudication of the complaint.

2.28.8 The CONTRACTOR shall develop and have available a standardized complaint form to provide to a complainant upon request. This complaint form shall be in a format specified by TENNCARE.

2.28.9 The CONTRACTOR shall report on non-discrimination activities as described in Section 2.30.21.

32. Section 2.29 shall be amended by deleting Section 2.29 in its entirety and replacing it with the following and renumbering all references thereto:

2.29 PERSONNEL REQUIREMENTS

2.29.1 Staffing Requirements

2.29.1.1 The CONTRACTOR shall have sufficient staffing capable of fulfilling the requirements of this Agreement.

2.29.1.2 The CONTRACTOR shall submit to TENNCARE the names, resumes and contact information of the key staff identified below. In the event of a change to any of the key staff identified in Section 2.29.1.3, the CONTRACTOR shall notify TENNCARE within ten (10) business days of the change.

2.29.1.3 The minimum key staff requirements are listed below. If a full-time staff person is required, that means that one person shall perform that function (as opposed to multiple persons equaling a full-time equivalent). If a full-time staff person is not specified, the position does not require a full-time staff person.

2.29.1.3.1 A full-time administrator/project director dedicated to the TennCare program who has clear authority over the general administration and day-to-day business activities of this Agreement;

2.29.1.3.2 [Left blank intentionally];

2.29.1.3.3 A full-time Medical Director dedicated to the TennCare program who is a licensed physician in the State of Tennessee to oversee and be responsible for all clinical activities, including but not limited to the proper provision of covered services to members, developing clinical practice standards and clinical policies and procedures;

2.29.1.3.4 A full-time senior executive dedicated to the TennCare program who is a board certified psychiatrist in the State of Tennessee and has at least five (5) years combined experience in mental health and substance abuse services. This person shall oversee and be responsible for all behavioral health activities;

2.29.1.3.5 A full-time senior executive dedicated to the TennCare CHOICES program who has at least five (5) years of experience administering managed long-term care programs. On a case-by-case basis, equivalent experience in administering long-term care programs and services, including HCBS, or in managed care may be substituted,

subject to the prior approval of TENNCARE. This person shall oversee and be responsible for all CHOICES activities in all of the Grand Regions;

- 2.29.1.3.5.1 The CONTRACTOR shall ensure that this position is filled at least one hundred and twenty (120) days prior to the scheduled implementation of CHOICES in the Middle Grand Region;
- 2.29.1.3.5.2 If the CONTRACTOR has not filled this position one hundred and eighty (180) days prior to the scheduled implementation of CHOICES in the Middle Grand Region, the CONTRACTOR shall designate another senior executive dedicated to the TennCare program to temporarily oversee CHOICES implementation activities, as prior approved by TENNCARE, until this position is filled (which, as specified in Section 2.29.1.3.5.1 above, shall be at least one hundred and twenty (120) days prior to the scheduled implementation of CHOICES in the Middle Grand Region). Should another senior executive be temporarily designated to oversee CHOICES implementation activities, upon filling the full-time position as specified in Section 2.29.1.3.5.1 above, the CONTRACTOR shall ensure the effective transition of all CHOICES implementation activities, including a minimum transition period of ninety (90) days;
- 2.29.1.3.6 A full-time chief financial officer dedicated to the TennCare program responsible for accounting and finance operations, including all audit activities;
- 2.29.1.3.7 A full-time staff information systems director/manager dedicated to the TennCare program responsible for all CONTRACTOR information systems supporting this Agreement who is trained and experienced in information systems, data processing and data reporting as required to oversee all information systems functions supporting this Agreement including, but not limited to, establishing and maintaining connectivity with TennCare information systems and providing necessary and timely reports to TENNCARE;
- 2.29.1.3.8 A staff person designated as the contact available after hours for the “on-call” TennCare Solutions staff to contact with service issues;
- 2.29.1.3.9 A staff person to serve as the CONTRACTOR’s Non-discrimination Compliance Coordinator. This person shall be responsible for compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), the Church Amendments (42 U.S.C. 300a-7), Section 245 of the Public Health Service Act (42 U.S.C. 238n.), and the Weldon Amendment (Consolidated Appropriations Act 2008, Public Law 110-161, Div. G, Sec. 508 (d), 121 Stat. 1844, 2209) on behalf of the CONTRACTOR. The CONTRACTOR shall report to TENNCARE in writing, to the attention of the Director of Non-Discrimination Compliance/Health Care Disparities, within ten (10) calendar days of the commencement of any period of time that the CONTRACTOR does not have a designated staff person for non-discrimination compliance. The CONTRACTOR shall report to TENNCARE at such time that the function is redirected as required in Section 2.29.1.2;

- 2.29.1.3.10 A full-time staff person dedicated to the TennCare program responsible for member services, who shall communicate with TENNCARE regarding member service activities;
- 2.29.1.3.11 A full-time staff person dedicated to the TennCare program responsible for provider services and provider relations, including all network development and management issues. This person shall be responsible for appropriate education regarding provider participation in the TennCare (including CHOICES) program; communications between the CONTRACTOR and its contract providers; and ensuring that providers receive prompt resolution of problems or inquiries. This person shall also be responsible for communicating with TENNCARE regarding provider service and provider relations activities. The FEA shall be responsible for education of and communication with consumer-directed workers, resolution of problems or inquiries from workers, and communication with TENNCARE regarding workers;
- 2.29.1.3.12 A full-time staff person dedicated to the TennCare CHOICES program responsible for educating and assisting long-term care providers and the FEA regarding appropriate claims submission processes and requirements, coding updates, electronic claims transactions and electronic funds transfer; for the development and maintenance of CONTRACTOR resources such as CHOICES provider manuals, website, fee schedules, etc.; for technical assistance regarding long-term care claims submission and resolution processes; and for prompt resolution of long-term care claims issues or inquiries as specified in Section 2.22.5. This person shall develop strategies to assess the effectiveness of the CONTRACTOR's claims education and technical assistance activities, gather feedback regarding the extent to which CHOICES long-term care providers are informed about appropriate claims submission processes and practices, and identify trends and guide the development of strategies to improve the efficiency of long-term care claims submission and resolution processes, as well as provider satisfaction. Unless and until directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, this staff person is not required to be full-time, and the requirements in this Section 2.29.1.3.12 only apply to nursing facility providers. If and when directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, this shall be a full-time staff person and the requirements shall apply to both nursing facility and HCBS providers and the FEA;
- 2.29.1.3.13 A staff person responsible for all fraud and abuse detection activities, including the fraud and abuse compliance plan, as set forth in Section 2.20 of this Agreement;
- 2.29.1.3.14 A staff person responsible for all UM activities, including but not limited to overseeing prior authorizations. This person shall be a physician licensed in the State of Tennessee and shall ensure that UM staff have appropriate clinical backgrounds in order to make utilization management decisions;
- 2.29.1.3.15 A staff person responsible for all QM/QI activities. This person shall be a physician or registered nurse licensed in the State of Tennessee;
- 2.29.1.3.16 A staff person responsible for all appeal system resolution issues;
- 2.29.1.3.17 A staff person responsible for all claims management activities;

- 2.29.1.3.18 A staff person assigned to provide legal and technical assistance for and coordination with the legal system for court ordered services;
- 2.29.1.3.19 A staff person responsible for all MCO case management and related issues, including but not limited to, disease management activities and coordination between physical and behavioral health services;
- 2.29.1.3.20 A full-time staff person dedicated to the TennCare CHOICES program who is a registered nurse and has at least three (3) years experience providing care coordination to persons receiving long-term care services and an additional two (2) years work experience in managed and/or long-term care. This person shall oversee and be responsible for all care coordination activities.
- 2.29.1.3.21 A sufficient number of CHOICES care coordinators that meet the qualifications in Section 2.9.6.11 to conduct all required activities as specified herein;
- 2.29.1.3.22 A consumer advocate for members receiving, or in need of, behavioral health services. This person shall be responsible for internal representation of members' interests including but not limited to: ensuring input in policy development, planning, decision making, and oversight as well as coordination of recovery and resilience activities;
- 2.29.1.3.23 Upon enrollment of members in CHOICES Group 2 and/or 3 (if and when directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3), a consumer advocate for CHOICES members. This person shall be responsible for internal representation of CHOICES members' interests including but not limited to input into planning and delivery of long-term care services, CHOICES QM/QI activities, program monitoring and evaluation, and member, family, and provider education. The consumer advocate shall also assist CHOICES members in navigating the CONTRACTOR's system (e.g., how to file a complaint, how to change care coordinators). This shall include, but not be limited to, helping members understand and use the CONTRACTOR's system, e.g., being a resource for members, providing information, making referrals to appropriate CONTRACTOR staff, and facilitating resolution of any issues. The consumer advocate shall also make recommendations to the CONTRACTOR on any changes needed to improve the CONTRACTOR's system for CHOICES members, make recommendations to TENNCARE regarding improvements for the CHOICES program, and participate as an ex officio member of the CHOICES Advisory Group required in Section 2.24.3;
- 2.29.1.3.24 A staff person responsible for TENNderCare services;
- 2.29.1.3.25 A staff person responsible for working with the Department of Children's Services;
- 2.29.1.3.26 A senior executive responsible for overseeing all subcontractor activities, if the subcontract is for the provision of covered benefits;
- 2.29.1.3.27 A staff person responsible for coordinating all activities and resolving issues related to CONTRACTOR/DBM coordination. This person shall be responsible for overseeing the work of the DBM Care Coordination Committee and the DBM Claims Coordination Committee as described in Section 2.9.11;

- 2.29.1.3.28 A staff person responsible for coordinating all activities and resolving issues related to CONTRACTOR/PBM coordination;
- 2.29.1.3.29 A staff person designated for interfacing and coordinating with the TDMHDD Planning and Policy Council; and
- 2.29.1.3.30 A specific staff person or persons designated as a liaison for the Department of Children's Services (DCS) which shall be identified, in writing, to TENNCARE and the DCS. The DCS liaison person(s) will be responsible for responsibilities described in Section 3.1.1 of this Agreement.
- 2.29.1.4 In addition to the key staff requirements described above, the CONTRACTOR shall have sufficient full-time clinical and support staff to conduct daily business in an orderly manner. This includes but is not limited to functions and services in the following areas: administration, accounting and finance, fraud and abuse, utilization management including prior authorizations, MCO case management, disease management, care coordination, QM/QI, member education and outreach, appeal system resolution, member services, provider services, provider relations, claims processing, and reporting.
- 2.29.1.5 The CONTRACTOR shall have a sufficient number of DBM care coordinators and claims coordinators to conduct all required activities, including but not limited to collaboration with the DBM and coordination with various state agencies.
- 2.29.1.6 The CONTRACTOR shall appoint specific staff to an internal audit function as specified in Section 2.21.10.
- 2.29.1.7 At least one hundred and twenty (120) days prior to the scheduled implementation of CHOICES in each Grand Region, the CONTRACTOR shall establish a team dedicated to the implementation of the CHOICES program. This team shall be responsible for directing and overseeing all aspects of the implementation of CHOICES. The team shall be led by the full-time senior executive referenced in Section 2.29.1.3.5 above and shall include, at a minimum, a staff person with responsibility for developing and implementing the CONTRACTOR's care coordination program, a staff person responsible for long-term care provider network development and provider relations, a staff person responsible for CHOICES provider claims education and assistance, a staff person responsible for long-term care QM/QI, a staff person responsible for IS issues related to CHOICES, and other staff as necessary to ensure the successful implementation of the CHOICES program and the seamless transition of members currently receiving long-term care services. The team shall report directly to the CONTRACTOR's senior management and shall interface with all of the CONTRACTOR's departments/business units as necessary to ensure the CONTRACTOR's readiness to provide services to CHOICES members in compliance with the requirements of this Agreement.
- 2.29.1.8 The CONTRACTOR is not required to report to TENNCARE the names of staff not identified as key staff in Section 2.29.1.3. However, the CONTRACTOR shall provide its staffing plan to TENNCARE.

- 2.29.1.9 The CONTRACTOR's project director, transition staff person, Medical Director, psychiatrist, CHOICES senior executive, financial staff, member services staff, provider services staff, provider relations staff, CHOICES provider claims education and assistance staff, UM staff, appeals staff, MCO case management staff, care coordination staff, consumer advocate (see Section 2.29.1.3.23), and TENNderCare staff person shall be located in the State of Tennessee. However, TENNCARE may authorize exceptions to this requirement. The CONTRACTOR shall seek TENNCARE's written prior approval to locate any of these staff outside of the State of Tennessee. The CONTRACTOR's request to locate required in-state staff to an out-of-state location shall include a justification of the request and an explanation of how services will be coordinated. If financial staff are not located in Tennessee the CONTRACTOR shall have the ability to issue a check within five (5) calendar days of a payment directive from TENNCARE.
- 2.29.1.10 The CONTRACTOR shall conduct training of staff in all departments to ensure appropriate functioning in all areas. This training shall be provided to all new staff members and on an ongoing basis for current staff.

2.29.2 **Licensure and Background Checks**

- 2.29.2.1 Except as specified in this Section 2.29.2.1 regarding the FEA, the CONTRACTOR is responsible for ensuring that all persons, whether they are employees, agents, subcontractors, providers or anyone acting for or on behalf of the CONTRACTOR, are legally authorized to render services under applicable state law. The FEA shall be responsible for ensuring that consumer-directed workers are qualified to provide HCBS to members in CHOICES Group 2 or 3 in accordance with TENNCARE requirements.
- 2.29.2.2 Except as specified in this Section 2.29.2.2 regarding the FEA, the CONTRACTOR is responsible for conducting background checks in accordance with state law and TennCare policy and ensuring that all employees, agents, subcontractors, providers or anyone acting for or on behalf of the CONTRACTOR conducts background checks in accordance with state law and TennCare policy. The FEA shall be responsible for conducting background checks on its staff, its subcontractors, and consumer-directed workers.

2.29.3 **Board of Directors**

The CONTRACTOR shall provide to TENNCARE, in writing, a list of all officers and members of the CONTRACTOR's Board of Directors. The CONTRACTOR shall notify TENNCARE, in writing, within ten (10) business days of any change thereto.

2.29.4 **Employment and Contracting Restrictions**

The CONTRACTOR shall not knowingly have a director, officer, partner, or person with beneficial ownership of more than five percent (5%) of the entity's equity who has been debarred or suspended by any federal agency. The CONTRACTOR may not have an employment, consulting, or any other agreement with a person that has been debarred or suspended by any federal agency for the provision of items or services that are significant and material to the entity's contractual obligation with the State. To the best of its knowledge and belief, the

CONTRACTOR certifies by its signature to this Agreement that the CONTRACTOR and its principals:

- 2.29.4.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal or state department or contractor;
- 2.29.4.2 Have not within a three (3) year period preceding this Agreement been convicted of, or had a civil judgment rendered against them from commission of fraud, or a criminal offense in connection with obtaining attempting to obtain, or performing a public (federal, state, or local) transaction or grant under a public transaction, violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property;
- 2.29.4.3 Are not presently indicted for or otherwise criminally or civilly charged by a government entity (federal, state, or local) with commission of any of the offenses detailed in Section 2.29.4.2 of this Agreement; and
- 2.29.4.4 Have not within a three (3) year period preceding this Agreement had one or more public transactions (federal, state, or local) terminated for cause or default.

33. Section 2.30 shall be amended by deleting Section 2.30 in its entirety and replacing it with the following and renumbering all references thereto:

2.30 REPORTING REQUIREMENTS

2.30.1 General Requirements

- 2.30.1.1 The CONTRACTOR shall comply with all the reporting requirements established by TENNCARE. TENNCARE shall provide the CONTRACTOR with the appropriate reporting formats, instructions, submission timetables, and technical assistance as required. TENNCARE may, at its discretion, change the content, format or frequency of reports. Unless and until directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the reporting requirements in Section 2.30 applicable only to CHOICES Group 2 and/or 3 will not apply. When directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the CONTRACTOR shall comply with all of the reporting requirements in Section 2.30.
- 2.30.1.2 TENNCARE may, at its discretion, require the CONTRACTOR to submit additional reports both ad hoc and recurring. If TENNCARE requests any revisions to the reports already submitted, the CONTRACTOR shall make the changes and re-submit the reports, according to the time period and format required by TENNCARE.
- 2.30.1.3 The CONTRACTOR shall submit all reports to TENNCARE, unless indicated otherwise in this Agreement, according to the schedule below:

DELIVERABLES	DUE DATE
Daily Reports	Within two (2) business days.
Weekly Reports	Wednesday of the following week.
Monthly Reports	20th of the following month.
Quarterly Reports	30th of the following month.
Semi-Annual Reports	January 31 and July 31.
Annual Reports	Ninety (90) calendar days after the end of the calendar year
On Request Reports	Within three (3) business days from the date of the request unless otherwise specified by TENNCARE.
Ad Hoc Reports	Within ten (10) business days from the date of the request unless otherwise specified by TENNCARE.

2.30.1.4 The CONTRACTOR shall submit all reports electronically and in the manner and format prescribed by TENNCARE. Except as otherwise specified by TENNCARE, reports may be statewide.

2.30.1.5 Except as otherwise provided in this Agreement, the CONTRACTOR shall submit all reports to the Bureau of TennCare.

2.30.1.6 The CONTRACTOR shall transmit to and receive from TENNCARE all transactions and code sets in the appropriate standard formats as specified under HIPAA and as directed by TENNCARE, so long as TENNCARE direction does not conflict with the law.

2.30.1.7 As part of its QM/QI program, the CONTRACTOR shall review all reports submitted to TENNCARE to identify instances and/or patterns of non-compliance, determine and analyze the reasons for non-compliance, identify and implement actions to correct instances of non-compliance and to address patterns of non-compliance, and identify and implement quality improvement activities to improve performance and ensure compliance going forward.

2.30.2 Eligibility, Enrollment and Disenrollment Reports

2.30.2.1 The CONTRACTOR shall comply with the requirements in Section 2.23.5 regarding eligibility and enrollment data exchange.

2.30.2.2 The CONTRACTOR shall submit a *Monthly Enrollment/Administrative Payment Reconciliation Report* that serves as a record that the CONTRACTOR has reconciled member eligibility data with administrative payments and verified that the CONTRACTOR has an enrollment record for all members for whom the CONTRACTOR has received an administrative payment.

2.30.2.3 The CONTRACTOR shall submit a *Quarterly Member Enrollment/Administrative Payment Report* in the event it has members for whom an administrative payment has

not been made or an incorrect payment has been made. This report shall be submitted on a quarterly basis, with a one-month lag time and is due to TENNCARE by the end of the second month following the reporting period. For example, for the quarter ending September 30, the report is due by the end of November and should include all data received through the end of October for the quarter ending September 30. These quarterly reports shall include all un-reconciled items until such time that TENNCARE notifies the CONTRACTOR otherwise.

- 2.30.2.4 TENNCARE may provide the CONTRACTOR with information on members for whom TENNCARE has been unable to locate or verify various types of pertinent information. Upon receipt of this information, the CONTRACTOR shall provide TENNCARE any information known by the CONTRACTOR that is missing or inaccurate in the report provided by TENNCARE. The CONTRACTOR shall submit this information to TENNCARE within the time frames specified by TENNCARE.
- 2.30.2.5 Until such time as an indicator for children in State custody and children transitioning out of State custody can be added to the daily eligibility updates received from TennCare, the CONTRACTOR shall reconcile enrollee eligibility data and administrative fee payments received from TennCare with an ad hoc report mutually agreed to by TennCare and the CONTRACTOR to facilitate timely identification of children in State custody or children transitioning out of State custody.
- 2.30.2.6 Pursuant to Section 2.4.6.2, the CONTRACTOR shall provide a listing of any enrollees for whom it has conflicting information to TennCare within ten (10) calendar days of the last day of each month.
- 2.30.2.7 The CONTRACTOR shall submit an *Immediate Eligibility Invoice* monthly in accordance with Attachment IX, Exhibit N.

2.30.3 LEFT BLANK INTENTIONALLY

2.30.4 Specialized Service Reports

- 2.30.4.1 The CONTRACTOR shall submit a quarterly *Psychiatric Hospital/RTF Readmission Report* that provides: the percentage of members readmitted to the facility within seven (7) calendar days of discharge (the number of members readmitted divided by the total number of discharges); the percent of members readmitted within thirty (30) calendar days of discharge (the number of members readmitted divided by the total number of discharges); and an analysis of the findings with any actions or follow-up planned. The information shall be reported separately for members age eighteen (18) and over and under eighteen (18).
- 2.30.4.2 The CONTRACTOR shall submit a quarterly *Mental Health Case Management Report* that provides information on mental health case management appointments and refusals (see Section 2.7.2.6). The minimum data elements required are identified in Attachment IX, Exhibit B.
- 2.30.4.3 The CONTRACTOR shall submit an annual *Supported Employment Report* that reports on the percent of SPMI adults receiving supported employment services that are gainfully employed in either part-time or full-time capacity for a continuous ninety (90) day period (defined as the number of adults receiving supported

employment for a continuous ninety (90) day period divided by the number of SPMI adults receiving supported employment services during the year) and an analysis of the findings with any action or follow-up planned as a result of the findings.

- 2.30.4.4 The CONTRACTOR shall submit a quarterly *Behavioral Health Crisis Response Report* that provides information on behavioral health crisis services (see Section 2.7.2.8) including the data elements listed in Attachment IX, Exhibit C. Specified data elements shall be reported separately for members ages eighteen (18) years and over and those under eighteen (18) years and all data elements shall be reported for each individual crisis service provider.
- 2.30.4.5 The CONTRACTOR shall submit a weekly *Member CRG/TPG Assessment Report* that contains information regarding the CRG assessments and TPG assessments (see Section 2.7.2.9) of members who have presented for mental health or substance abuse services or who have received CRG assessments and TPG assessments prior to obtaining such services. For purposes of this weekly *Member CRG/TPG Assessment Report*, the weekly report shall be due no later than 12:00 Noon, each Tuesday. The minimum data elements required are identified in Attachment IX, Exhibit D of this Agreement.
- 2.30.4.6 On a quarterly basis the CONTRACTOR shall submit a *Rejected CRG/TPG Assessments Report* that provides, by agency, the number of rejected CRG/TPG assessments and the unduplicated number of and identifying information for the unapproved raters who completed the rejected assessments.
- 2.30.4.7 The CONTRACTOR shall submit an annual *CRG/TPG Assessments Audit Report*. The report shall contain the results of the CONTRACTOR's audits for the prior year of CRG/TPG assessments for accuracy and conformity to state policies and procedures.
- 2.30.4.8 The CONTRACTOR shall annually submit to TENNCARE its methodology for conducting the CRG/TPG assessment audits on March 1.
- 2.30.4.9 The CONTRACTOR shall submit a quarterly *TENnderCare Report*.

2.30.5 **Disease Management Reports**

- 2.30.5.1 The CONTRACTOR shall submit a quarterly *Disease Management Update Report* that includes, for each disease management program (see Section 2.8), a brief narrative description of the program, the total number of members in the program, the total number of members enrolled and disenrolled during the quarter, and a description of the specific provider and member interventions performed during the quarter. The report shall include a chart and narrative for CHOICES members in DM to include the total number of members receiving DM interventions, by DM condition; the total number of CHOICES members starting and terminating DM interventions during the quarter, a description of any specific provider and member interventions that were new during the quarter, the number of member and provider activities/interventions, and a written analysis of data provided.
- 2.30.5.2 The CONTRACTOR shall submit on July 1 an annual *Disease Management Report* that includes, for each disease management programs, a narrative description of the

eligibility criteria and the method used to identify and enroll eligible members, the passive participation rate as defined by NCQA (the percentage of identified eligible members who have received an intervention divided by the total population who meet the criteria for eligibility), the total number of active members having one or more of the diagnosis codes (ICD-9 Codes) relating to each of the disease management programs, a description of stratification levels for each DM program including member criteria and associated interventions, a discussion of barriers and challenges to include resources, program structure, member involvement and provider participation, a summary of member satisfaction with the DM program, a written analysis of the data presented, a description of proposed changes to program, and information on the programs' activities, benchmarks and goals as described in Section 2.8.7. The report shall include a separate chart(s) and narrative for CHOICES members in DM to include a narrative description of the eligibility criteria and the method used to identify and enroll eligible CHOICES members, a description of stratification levels based on the setting in which the member resides; total number of CHOICES members identified as having a DM condition, total number of members receiving DM activities/interventions, and the number of CHOICES members by level of stratification; a discussion of barriers and challenges to include resources, program structure, member involvement, and provider participation along with a description of proposed changes.

- 2.30.5.3 The CONTRACTOR shall submit annually an updated *Disease Management Program Description* to include at a minimum the disease management components listed in Sections 2.8.1.4 through 2.8.1.6 of this Agreement.

2.30.6 Service Coordination Reports

2.30.6.1 MCO Case Management Reports

- 2.30.6.1.1 The CONTRACTOR shall submit annually an updated *MCO Case Management Program Description* to TENNCARE describing the CONTRACTOR's MCO case management services. The report shall include a description of the criteria and process the CONTRACTOR uses to identify members for MCO case management, the process the CONTRACTOR uses to inform members and providers of the availability of MCO case management, a description of the MCO case management services provided by the CONTRACTOR and the methods used by the CONTRACTOR to evaluate its MCO case management program. CHOICES information shall also be included in this report.
- 2.30.6.1.2 The CONTRACTOR shall submit an annual *MCO Case Management Services Report* that addresses the activities in Section 2.9.5 of this Agreement by July 1 of each year.
- 2.30.6.1.3 The CONTRACTOR shall submit a quarterly *MCO Case Management Update Report*. Enrollees who are enrolled in Disease Management need not be included in this report unless they are also receiving case management.
- 2.30.6.2 For the first six (6) months after implementation of CHOICES in each Grand Region, or as long as determined necessary by TENNCARE, the CONTRACTOR shall submit a monthly *Status of Transitioning CHOICES Members Report* that provides information regarding transitioning CHOICES members (see Section 2.9.3). The

report shall include information on the CONTRACTOR's current and cumulative performance on various measures.

The performance measures shall include but not be limited to the following:

- (1) Of CHOICES Group 1 members who were enrolled in CHOICES as of the CHOICES implementation date, the number and percent for whom the CONTRACTOR has/has not conducted a face-to-face visit (see Section 2.9.3.7)
- (2) Of CHOICES Group 2 members who were enrolled in CHOICES as of the CHOICES implementation date, the number and percent for whom the CONTRACTOR has/has not conducted face-to-face visit and a comprehensive needs assessment and developed and authorized a new plan of care

2.30.6.3 Upon enrollment of CHOICES Group 2 or 3 members (if and when directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3), the CONTRACTOR shall submit a semi-annual *CHOICES Nursing Facility Diversion Activities Report*. The report shall provide a description of the CONTRACTOR's nursing facility diversion activities by each of the groups specified in Section 2.9.6.7, including a detailed description of the CONTRACTOR's success in identifying members for diversion, in diverting members, and in maintaining members in the community, as well as lessons learned, including a description of factors affecting the CONTRACTOR's ability to divert members, identified issues, strategies to address identified issues, and opportunities for systemic improvements in the CONTRACTOR's nursing facility diversion process(es).

2.30.6.4 The CONTRACTOR shall submit a quarterly *CHOICES Nursing Facility to Community Transition Report*. The report shall include information, by month, on specified measures, which shall include but not be limited to the following:

- (1) Number of CHOICES members transitioned from a nursing facility
- (2) Of members who transitioned from a nursing facility, the number and percent of members who transitioned to:
 - (a) A community-based residential alternative facility
 - (b) A residential setting where the member will be living independently
 - (c) A residential setting where the member will be living with a relative or other caregiver
- (3) Of members who transitioned from a nursing facility, the number and percent of members who:
 - (a) Are still in the community
 - (b) Returned to a nursing facility within ninety (90) days after transition
 - (c) Returned to a nursing facility more than ninety (90) days after transition
- (4) Number of CHOICES members identified as potential candidates for transition from a nursing facility

- (5) Of members identified as potential candidates for transition, the number and percent of members who were identified:
 - (a) By referral (by type of referral, including but not limited to referral by treating physician, nursing facility, community-based organization, family, self, and other)
 - (b) Via the MDS
 - (c) Via care coordination
 - (d) By other source

2.30.6.5 Upon enrollment of CHOICES Group 2 or 3 members (if and when directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3), the CONTRACTOR shall submit a monthly *CHOICES HCBS Late and Missed Visits Report* for CHOICES members regarding the following HCBS services: personal care, attendant care, homemaker services, and home-delivered meals. The report shall include information on specified measures, which shall include but not be limited to the following:

- (1) Total number of members enrolled in CHOICES Group 2, Group 3, and in CHOICES Groups 2 and 3 combined
- (2) Total number of CHOICES members with scheduled visits for each service type (personal care, attendant care, homemaker, and home-delivered meals), by provider type (agency provider or consumer-directed worker)
- (3) Total number of scheduled visits for each service type, by provider type
- (4) Of the total number of scheduled visits for each service type, by provider type; the percent that were:
 - (a) On-time
 - (b) Late
 - (c) Missed
- (5) Of the total number of late visits for each service type, by provider type; the percent that were:
 - (a) Member-initiated
 - (b) Provider-initiated
 - (c) Due to weather/natural disaster
- (6) Of the total number of late visits for each service type, by provider type; the number that were:
 - (a) Member-initiated, by reason code
 - (b) Provider-initiated, by reason code
 - (c) Due to weather/natural disaster
- (7) Of the total number of missed visits for each service type, by provider type; the percent that were:
 - (a) Member-initiated
 - (b) Provider-initiated
 - (c) Due to weather/natural disaster

- (8) Of the total number of missed visits for each service type, by provider type; the number that were:
 - (a) Member-initiated, by reason code
 - (b) Provider-initiated, by reason code
 - (c) Due to weather/natural disaster
- (9) Of the total number of missed visits for each service type, by provider type; the number and percent that were:
 - (a) Made-up by paid support – provider staff
 - (b) Made-up by paid support – worker
 - (c) Made-up by unpaid support
 - (d) Not made-up

2.30.6.6 Upon enrollment of CHOICES Group 2 or 3 members (if and when directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3), the CONTRACTOR shall submit a quarterly *CHOICES Consumer Direction of HCBS Report*. The report shall include current information, by month, on specified measures, which shall include but not be limited to the following:

- (1) Total number of members enrolled in CHOICES Group 2, Group 3, and in CHOICES Groups 2 and 3 combined
- (2) The number and percent of members in CHOICES Groups 2 and 3 (combined) enrolled in consumer direction of HCBS
- (3) Number of members referred to the FEA (for enrollment in consumer direction)
- (4) Maximum and average time from FEA referral to receipt of consumer directed services
- (5) Number and percent of members enrolled in consumer direction who began initial enrollment in consumer direction (for each month in the reporting period)
- (6) Number and percent of members enrolled in consumer direction who withdrew from consumer direction (for each month in the reporting period)
- (7) Number and percent of members enrolled in consumer direction who have a representative to assist the member in consumer direction
- (8) The number and percent of member receiving consumer directed services by type of consumer directed service (attendant care, companion care, homemaker, in-home respite, or personal care)

2.30.6.7 The CONTRACTOR shall submit a quarterly *CHOICES Care Coordination Report*, in a format specified by TENNCARE that includes, but is not limited to, information on care coordination staffing, enrollment and care coordination contacts, ongoing assessment, care planning and service initiation, and self-directed healthcare tasks. The report shall also include a narrative of quarterly activities.

- 2.30.6.8 As necessary, the CONTRACTOR shall submit a listing of members identified as potential pharmacy lock-in candidates (see Section 2.9.10.3.2).
- 2.30.6.9 The CONTRACTOR shall submit a quarterly *Pharmacy Services Report* that includes a list of the providers and information on the interventions the CONTRACTOR has taken with the providers who appear to be operating outside industry or peer norms as defined by TENNCARE, have been identified as non-compliant as it relates to adherence to the PDL and/or generic prescribing patterns and/or are failing to follow required prior authorization processes and procedures the steps the CONTRACTOR has taken to personally contact each one as well as the outcome of these personal contacts.
- 2.30.6.10 The CONTRACTOR shall submit a *Pharmacy Services Report, On Request* when TENNCARE requires assistance in identifying and working with providers for any reason. These reports shall provide information on the activities the CONTRACTOR undertook to comply with TENNCARE's request for assistance, outcomes (if applicable) and shall be submitted in the format and within the time frame prescribed by TENNCARE.

2.30.7 **Provider Network Reports**

- 2.30.7.1 The CONTRACTOR shall submit a monthly *Provider Enrollment File* that includes information on all providers of TennCare health services, including physical, behavioral health, and long-term care providers (see Section 2.11). This includes but is not limited to, PCPs, physician specialists, hospitals, home health agencies, CMHAs, nursing facilities, HCBS providers (as applicable), and emergency and non-emergency transportation providers. For HCBS providers, the *Provider Enrollment File* shall identify the type(s) of HCBS the provider is contracted to provide and the specific counties in which the provider is contracted to deliver HCBS, by service type. The report shall include contract providers as well as all non-contract providers with whom the CONTRACTOR has a relationship. The report shall be sorted by provider type. The CONTRACTOR shall submit this report during readiness review, by the 5th of each month, and upon TENNCARE request. Each monthly *Provider Enrollment File* shall include information on all providers of covered services and shall provide a complete replacement for any previous *Provider Enrollment File* submission. Any changes in a provider's contract status from the previous submission shall be indicated in the file generated in the month the change became effective and shall be submitted in the next monthly file.
- 2.30.7.2 The CONTRACTOR shall submit an annual *Provider Compliance with Access Requirements Report* that summarizes the CONTRACTOR's monitoring activities, findings, and opportunities for improvement regarding provider compliance with applicable access standards. (See Section 2.11.1.10.)
- 2.30.7.3 The CONTRACTOR shall submit a quarterly *PCP Assignment Report* that provides the following information for non-dual members: Provider Name, Provider Medicaid I.D. Number, NPI Number, Number of Enrollees assigned by Enrollee Age Category. The enrollee age categories shall be consistent with the following: Age Under 1, Age 1 – 13, Age 14 – 20, Age 21- 44, Age 45 – 64, Age 65 +. (See Section 2.11.2.)

- 2.30.7.4 The CONTRACTOR shall submit an annual *Report of Essential Hospital Services* by September 1 of each year. The CONTRACTOR shall use the format in Attachment IX, Exhibit G.
- 2.30.7.5 The CONTRACTOR shall submit a quarterly *Behavioral Health Initial Appointment Timeliness Report* that shall include the average time between the intake assessment appointment and the member's next scheduled appointment or admission. The report shall provide this information by type of service and shall include an analysis of the findings and any actions or follow-up planned as a result of the findings.
- 2.30.7.6 The CONTRACTOR shall submit an annual *Long-Term Care Provider Network Development Plan* that includes all of the elements specified in Section 2.11.6.6 of this Agreement.
- 2.30.7.7 The CONTRACTOR shall submit a quarterly *Long-Term Care Provider Capacity Performance Report* that provides information on the CONTRACTOR's performance with respect to the performance standards and benchmarks established by TENNCARE pursuant to Section 2.11.6.5.
- 2.30.7.8 The CONTRACTOR shall submit an annual *CHOICES Qualified Workforce Strategies Report* that describes the CONTRACTOR's strategies to assist in the development of an adequate qualified workforce for covered long-term care services, increase the available qualified direct care staff, and improve the retention of qualified direct care staff (see Section 2.11.6.7). At a minimum, the report shall include a brief description of each of the CONTRACTOR's strategies; activities associated with each of the CONTRACTOR's strategies, including associated partnerships; timeframes for implementing each strategy and associated activities; the status of each strategy and associated activities; and a brief summary of the current and anticipated impact of each strategy and associated activities.
- 2.30.7.9 The CONTRACTOR shall submit an annual *FQHC Report* by January 1 of each year. The CONTRACTOR shall use the form provided in Attachment IX, Exhibit H.
- 2.30.7.10 The CONTRACTOR shall submit a monthly *Institutions for Mental Diseases (IMD) Out-of-State Report* on the use of IMDs utilized outside of the State of Tennessee. The report shall be submitted by the 5th of each month for the previous month.

2.30.8 **Provider Agreement Report**

The CONTRACTOR shall submit a monthly *Single Case Agreements Report* using the format provided in Attachment IX, Exhibit I. (See Section 2.12.4.)

2.30.9 **Provider Payment Reports**

- 2.30.9.1 The CONTRACTOR shall submit a quarterly *Related Provider Payment Report* that lists all related providers and subcontractors to whom the CONTRACTOR has made payments during the previous quarter and the payment amounts. (See Section 2.13.19.)
- 2.30.9.2 The CONTRACTOR shall submit a weekly *Invoice* to notify the State of the amount to be paid to providers at least 72 hours in advance of distribution of provider checks.

- 2.30.9.3 The CONTRACTOR shall submit a *Check Register Report* with the weekly Invoice to support the payments released to providers.
- 2.30.9.4 The CONTRACTOR shall submit a *Claims Data Extract* within seven (7) calendar days after the CONTRACTOR's request of the funds which shall be generated from the managed care claims processing system supporting the release of provider and FEA (for consumer-directed workers, as applicable) payments. (See Section 2.13.1.)
- 2.30.9.5 The CONTRACTOR shall submit a *Reconciliation Report* within seven (7) days of the claims data extract for the total paid amounts between the funds released for payment to providers and the FEA (for consumer-directed workers, as applicable) , the supporting claims data extract, and the encounter data submissions for the relevant adjudication cycle.
- 2.30.9.6 If the CONTRACTOR does not automatically credit TennCare for receivables within ninety (90) calendar days, the CONTRACTOR shall submit a *Provider Payment Issue Report* and shall determine the extent of the collection effort required based on the table below. This table identifies the minimum collection threshold for cumulative receivable balances. All collection efforts shall be clearly documented.

Receivable Balance	Collection Attempts		Forwarded to Collections
	45 Day	90 Day	
< \$10	None Required		
\$10 - \$49.99	✓		
\$50 - \$99.99	✓	✓	
\$100 - Over	✓	✓	✓
Responsibility	MCC		TENNCARE

- 2.30.9.6.1 The first notice shall occur by day forty-five (45) and may be in the form of notice in a remittance advice or a demand memo; however, the ninety (90) day notice must be made using a demand memo. Each of these notices shall be sent within five (5) business days of becoming due.
- 2.30.9.6.2 Additional collection attempts by the CONTRACTOR are not necessary if a collection notice is returned because the provider has gone out-of-business or has declared bankruptcy for the period the receivable was established. This circumstance must be reported in the "Uncollectible Accounts Report" as described below.
- 2.30.9.7 If the CONTRACTOR does not automatically credit TENNCARE for aged accounts within sixty (60) calendar days, the CONTRACTOR shall submit to TENNCARE, within ten (10) business days following the end of the month, an *Aged Accounts Receivable Report*. The effective date of this report shall be the last Friday of the previous month. The report shall have an easily identifiable date, contain a total report balance, and provide <30, 30, 60, 90, and >120 calendar day balances. Although only totals are required, the CONTRACTOR may report aging balances at the account level. If the CONTRACTOR is not reporting at the account level, the CONTRACTOR shall have the capability to identify the detail that makes up a total if necessary.

- 2.30.9.8 If the CONTRACTOR does not automatically credit TENNCARE for uncollectible accounts within ninety (90) calendar days, the CONTRACTOR shall submit to TENNCARE, within ten (10) business days following the end of the month, an *Uncollectible Accounts Report*, in a format described by TENNCARE, for accounts meeting the following criteria:
 - 2.30.9.8.1 the account proves to be uncollectible after 120 calendar days, or
 - 2.30.9.8.2 the provider account owner has gone out-of-business, or
 - 2.30.9.8.3 the provider account owner has declared bankruptcy.
- 2.30.9.9 In addition to the *Uncollectible Accounts Report*, the CONTRACTOR shall submit scanned copies of returned envelopes or legal documents referencing providers that have gone out-of-business and/or declared bankruptcy.
- 2.30.9.10 The CONTRACTOR shall submit a monthly *Outstanding Checks Report* detailing all checks remitted to providers, enrollees or vendors on behalf of the State which remain outstanding (which have not been cashed) greater than one hundred eighty (180) calendar days. Reports are due within fifteen (15) business days after the end of the month.

2.30.10 Utilization Management Reports

- 2.30.10.1 The CONTRACTOR shall annually submit, by July 30th of each year, a UM program description and an associated work plan and evaluation. These documents must be prior approved by the CONTRACTOR's oversight committee prior to submission to TENNCARE. The annual evaluation shall include an analysis of findings and actions taken.
- 2.30.10.2 The CONTRACTOR shall submit quarterly *Cost and Utilization Reports*. These reports shall be in an Excel spreadsheet format and submitted with a ninety (90) day lag and shall be due to TENNCARE one hundred five (105) calendar days following the quarter for which the CONTRACTOR is reporting. These reports shall be submitted on both a cumulative year basis and on a rolling twelve (12) month basis.
- 2.30.10.3 The CONTRACTOR shall provide quarterly *Cost and Utilization Summaries*. These summaries shall report on services paid during the previous quarter. The summaries shall include all data elements listed in Attachment IX, Exhibit K. The CONTRACTOR shall provide the reports separately for the populations specified by TENNCARE.
- 2.30.10.4 The CONTRACTOR shall identify and report the number of members who incurred non-nursing facility claims in excess of twenty-five thousand dollars (\$25,000) on a rolling quarterly basis (high-cost claimants). The CONTRACTOR shall report the member's age, sex, primary diagnosis, and amount paid by claim type for each member. The name, and other identifying information of the member shall be blinded in order to maintain confidentiality.
- 2.30.10.5 The CONTRACTOR shall submit a monthly *CHOICES Utilization Report*. The report shall include a summary overview that includes the number of CHOICES

member who have not received any long-term care services within thirty (30) to fifty-nine (59) days, within sixty (60) to eighty-nine (89) days, or in ninety (90) days or more. The report shall also include detailed member data for members who have not received services in the last thirty (30) days, including the member's name, social security number, CHOICES group, and CHOICES enrollment date; date of last long-term care service; length of time without long-term care services; whether and when long-term care services will resume; and the reason/explanation why the member has not received long-term care services.

- 2.30.10.6 The CONTRACTOR shall submit quarterly *Prior Authorization Reports* that include information, by service and separately for adults and children, on the number of requests received, number processed, number approved, number denied, and denial reason.
- 2.30.10.7 The CONTRACTOR shall submit a copy of the *Referral Provider Listing* (see Section 2.14.3.5), a data file of the provider information used to create the listing, and documentation from the CONTRACTOR's mail room or outside vendor indicating the quantity of the referral provider listings mailed to providers, the date mailed, and to whom. The CONTRACTOR shall submit this information at the same time it is sent to the providers as required in Section 2.14.3.5.
- 2.30.10.8 The CONTRACTOR shall submit a semi-annual *Emergency Department Threshold Report* to TENNCARE no later than February 28th and August 31st each year identifying interventions initiated for members who exceeded the defined threshold for ED usage.

2.30.11 **Quality Management/Quality Improvement Reports**

- 2.30.11.1 The CONTRACTOR shall annually submit, by July 30, an approved (by the CONTRACTOR's QM/QI Committee) QM/QI Program Description, Associated Work Plan, and Annual Evaluation.
- 2.30.11.2 The CONTRACTOR shall submit an annual *Report on Performance Improvement Projects* that includes the information specified in Section 2.15.3. The report shall be submitted annually on July 30.
- 2.30.11.3 The CONTRACTOR shall submit its *NCQA Accreditation Report* (the final bound copy from NCQA) immediately upon receipt, but not to exceed ten (10) calendar days from notification by NCQA.
- 2.30.11.4 The CONTRACTOR shall submit its annual reevaluation of accreditation status based on HEDIS scores immediately upon receipt, but not to exceed ten (10) calendar days from notification by NCQA.
- 2.30.11.5 The CONTRACTOR shall submit an annual *Report of Audited CAHPS Results and Audited HEDIS Results* by June 15 of each year (see Section 2.15.6).
- 2.30.11.6 Upon enrollment of members in CHOICES Group 2 and/or 3 (if and when directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3), the CONTRACTOR shall submit a quarterly *CHOICES HCBS Critical Incidents Report* (see Section 2.15.7) that provides information, by

month regarding specified measures, which shall include but not be limited to the following:

- (1) The number of members in CHOICES Group 2, Group 3, and CHOICES Groups 2 and 3 combined
- (2) The number of critical incidents, overall and by:
 - (a) Type of incident
 - (b) Setting
 - (c) Type of provider (provider agency or consumer-directed worker)
- (3) The percent of incidents by type of incident
- (4) The percent of members in CHOICES Groups 2 and 3 with an incident

2.30.12 Customer Service Reports/Provider Service Reports

2.30.12.1 Member Services/Provider Services/ED Phone Line Reports

2.30.12.1.1 The CONTRACTOR shall submit a quarterly *Member Services, Provider Services, and Utilization Management Phone Line Report*. The data in the report shall be recorded by month and shall include the detailed rate calculations. The CONTRACTOR shall submit the report in the format specified in Attachment IX, Exhibit M.

2.30.12.1.2 The CONTRACTOR shall submit a quarterly *24/7 Nurse Triage Line Report* that lists the total calls received by the 24/7 nurse triage line, including the number of calls from CHOICES members, including the ultimate disposition of the call (e.g. education only, no referral for care; referred to primary care provider for care, referred to emergency department for care, transfers to a care coordinator (for CHOICES members)). If the CONTRACTOR uses the 24/7 nurse line to fulfill the requirements set forth in Section 2.18.4.7 of this Agreement, such calls shall be separately delineated in the report in accordance with the requirements described in Section 2.30.12.1.3 of this Agreement.

2.30.12.1.3 The CONTRACTOR shall submit a quarterly *ED Assistance Tracking Report* that provides the total number of calls received pertaining to patients in EDs needing assistance in accessing care in an alternative setting. Such report shall include the date and time of the call, identifying information for the member, the name and location of the hospital, the ultimate response to the call (e.g. appointment made with PCP) and the elapsed time from ED visit until appointment in alternative setting. If the CONTRACTOR uses the nurse triage line to provide appointment assistance to non-emergency ED patients, the aforementioned information may be provided in conjunction with the report discussed at Section 2.30.12.1.2.

2.30.12.2 The CONTRACTOR shall report separately any member services or utilization management phone lines operated by subcontractors.

2.30.12.3 The CONTRACTOR shall submit a quarterly *Translation/Interpretation Services Report*. The report shall list each request and include the name and member identification number for each member to whom translation/interpretation service

was provided, the date of the request, the date provided, and the identification of the translator/interpreter.

- 2.30.12.4 The CONTRACTOR shall submit an annual *Provider Satisfaction Survey Report* that encompasses behavioral and physical health as well as survey results for CHOICES long-term care providers. The report shall summarize the provider survey methods and findings for each of the three groups and must provide an analysis of opportunities for improvement (see Sections 2.18.7.4 and 2.18.7.5) in addition to CHOICES items specified in the protocols provided by TENNCARE.
- 2.30.12.5 The CONTRACTOR shall submit a quarterly *Provider Complaints Report* that provides information on the number and type of provider complaints received, either in writing or by phone, by type of provider, and the disposition/resolution of those complaints. The data shall be reported by month.

2.30.13 Member Complaints

Upon receipt of a reporting template from TENNCARE and in accordance with specified timeframes for implementing the new report, the CONTRACTOR shall begin submitting a quarterly *Member Complaints Report* (see Section 2.19.2) that includes information, by month, regarding specified measures, which shall include but not be limited to the following:

- (1) The number of complaints received in the month, overall, by type, and by CHOICES Group (if the member is a CHOICES member)
- (2) The number and percent of complaints for which the CONTRACTOR met/did not meet the specified timeframe for resolution (see Section 2.19.2.5)

The report shall also include identification of any trends regarding complaints (e.g., the type or number of complaints) and any action steps to address these trends, including quality improvement activities.

2.30.14 Fraud and Abuse Reports

- 2.30.14.1 The CONTRACTOR shall submit an annual *Fraud and Abuse Activities Report*. This report shall summarize the results of its fraud and abuse compliance plan (see Section 2.20) and other fraud and abuse prevention, detection, reporting, and investigation measures, and should cover results for the fiscal year ending June 30. The report shall be submitted by September 30 of each year in the format reviewed and approved by TENNCARE (as part of the CONTRACTOR's compliance plan).
- 2.30.14.2 The CONTRACTOR shall submit an annual fraud and abuse compliance plan (see Section 2.20.3 of this Agreement).
- 2.30.14.3 On an annual basis the CONTRACTOR shall submit its policies for employees, contractors, and agents that comply with Section 1902(a)(68) of the Social Security Act. These policies shall be submitted by July 1 of each year.

2.30.15 Financial Management Reports

2.30.15.1 Third Party Liability (TPL) Resources Reports

2.30.15.1.1 The CONTRACTOR shall submit a monthly, quarterly and annual *Recovery and Cost Avoidance Report* that includes any recoveries for third party resources as well as funds for which the CONTRACTOR does not pay a claim due to TPL coverage or Medicare coverage. This CONTRACTOR shall calculate cost savings in categories described by TENNCARE.

2.30.15.1.2 The CONTRACTOR shall submit an *Other Insurance Report* that provides information on any members who have other insurance, including long-term care insurance. This report shall be submitted in a format and frequency described by TENNCARE.

2.30.15.2 Financial Reports to TENNCARE

2.30.15.2.1 For the purpose of monitoring actual medical expenses, TennCare shall establish a Medical Fund Target by eligibility grouping for TennCare Select. The CONTRACTOR shall submit a monthly *Medical Fund Target Report* with cumulative year to date calculation. The CONTRACTOR shall report all medical expenses and complete the supporting claims lag tables. This report shall be accompanied by a letter from an actuary, who may be an employee of the CONTRACTOR, indicating that the reports, including the estimate for incurred but not reported expenses, has been reviewed for accuracy. The CONTRACTOR shall also file this report with its NAIC filings due in March and August of each year using an accrual basis that includes incurred but not reported amounts by calendar service period that have been certified by an actuary. This report shall reconcile to NAIC filings including the supplemental TennCare income statement. The CONTRACTOR shall also reconcile the amount paid reported on the supporting claims lag tables to the amount paid for the corresponding period as reported on the CONTRACTOR's encounter file submission as specified in Sections 2.30.17.3 and 2.23.4.

2.30.15.2.2 The CONTRACTOR shall submit an annual *Ownership and Financial Disclosure Report* to TENNCARE. This report shall include full and complete information regarding ownership, financial transactions and persons as described in Section 2.21.9 and shall be submitted March 1 of each calendar year and at other times as required by TENNCARE.

2.30.15.2.3 The CONTRACTOR shall submit its annual audit plan on March 1 of each year (see Section 2.21.1.10).

2.30.15.3 TDCI Financial Reports

2.30.15.3.1 By no later than December 31 of each year, the CONTRACTOR shall submit to TDCI an annual *Financial Plan and Projection of Operating Results Report*. This submission shall include the CONTRACTOR's budget projecting revenues earned and expenses incurred on a calendar year basis through the term of this Agreement. This budget shall be prepared in accordance with the form prescribed by TDCI and shall include narratives explaining the assumptions and calculations utilized in the projections of operating results.

- 2.30.15.3.2 By no later than July 31 of each year, the CONTRACTOR shall submit to TDCI a mid-year *Comparison of Actual Revenues and Expenses to Budgeted Amounts Report*. If necessary, the CONTRACTOR shall revise the calendar year budget based on its actual results of operations. Any revisions to the budget shall include narratives explaining the assumptions and calculations utilized in making the revisions.
- 2.30.15.3.3 The CONTRACTOR shall submit to TDCI an *Annual Financial Report* required to be filed by all licensed health maintenance organizations pursuant to TCA 56-32-108. This report shall be on the form prescribed by the National Association of Insurance Commissioners (NAIC) for health maintenance organizations and shall be submitted to TDCI on or before March 1 of each calendar year. It shall contain an income statement detailing the CONTRACTOR's fourth quarter and year-to-date revenues earned and expenses incurred as a result of the CONTRACTOR's participation in the TennCare program. The CONTRACTOR in preparing this annual report shall comply with any and all rules and regulations of TDCI related to the preparation and filing of this report. This Annual Report shall also be accompanied by the Medical Fund Target report, where applicable, completed on a calendar year basis. The CONTRACTOR shall submit a reconciliation of the Medical Fund Target report to the annual NAIC filing using an accrual basis that includes an actuarial certification of the claims payable (reported and unreported).
- 2.30.15.3.4 The CONTRACTOR shall file with TDCI, a *Quarterly Financial Report*. These reports shall be on the form prescribed by the National Association of Insurance Commissioners for health maintenance organizations and shall be submitted to TDCI on or before May 15 (covering first quarter of current year), August 15 (covering second quarter of current year) and November 15 (covering third quarter of current year). Each quarterly report shall also contain an income statement detailing the CONTRACTOR's quarterly and year-to-date revenues earned and expenses incurred as a result of the CONTRACTOR's participation in the TennCare program. The second quarterly report (submitted on August 15) shall include the Medical Fund Target report completed on an accrual basis that includes an actuarial certification of the claims payable (reported and unreported) and, if any, other actuarial liabilities reported. The actuarial certification shall be prepared in accordance with National Association of Insurance Commissioners guidelines. The CONTRACTOR shall also submit a reconciliation of the Medical Fund Target report to the second quarterly NAIC report.
- 2.30.15.3.5 The CONTRACTOR shall submit to TDCI annual *Audited Financial Statements*. Such audit shall be performed in accordance with NAIC Annual Statement Instructions regarding the annual audited financial statements. There are three (3) exceptions to the NAIC statement instructions:
- 2.30.15.3.5.1 The CONTRACTOR shall submit the audited financial statements covering the previous calendar year by May 1 of each calendar year.
- 2.30.15.3.5.2 Any requests for extension of the May 1 submission date must be granted by the Office of the Comptroller of the Treasury pursuant to the "Contract to Audit Accounts."

- 2.30.15.3.5.3 The report shall include an income statement addressing the TENNCARE operations of the CONTRACTOR.

2.30.16 Claims Management Reports

- 2.30.16.1 The CONTRACTOR shall submit a monthly *Claims Payment Accuracy Report*. The report shall include the results of the internal audit of the random sample of all “processed or paid” claims (described in Section 2.22.6) and shall report on the number and percent of claims that are paid accurately. As provided in Section 2.22.6.6, if the CONTRACTOR subcontracts for the provision of any covered services, and the subcontractor is responsible for processing claims, then the CONTRACTOR shall submit a claims payment accuracy percentage report for the claims processed by the subcontractor. The report for each subcontractor shall include the results of the internal audit conducted in compliance with Section 2.22.6 and shall report on the number and percent of claims that are paid accurately.
- 2.30.16.2 The CONTRACTOR shall submit a quarterly *Explanation of Benefits (EOB) Report*. This report shall summarize the number of EOBs sent by category, member complaints, and complaint resolution (including referral to TBI/OIG). (See Section 2.22.8.)
- 2.30.16.3 The CONTRACTOR shall submit a weekly *Claims Activity Report*. This report shall identify the number of claims received, number of claims denied (by reason), number of claims paid, and total amount paid by the categories of service specified by TENNCARE.
- 2.30.16.4 Upon enrollment of members in CHOICES Group 2 and/or 3 (if and when directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3), the CONTRACTOR shall submit a quarterly *CHOICES Cost Effective Alternative Services Report* that provides information on cost effective alternative services provided to CHOICES members (see Section 2.6.5.2). The report shall provide information regarding specified measures, including but not limited to the following:
- (1) The number of members in CHOICES Group 2, CHOICES Group 3, and CHOICES Groups 2 and 3 combined
 - (2) The number and percent of members authorized to receive cost effective alternative (CEA) HCBS in excess of a benefit limit, overall and by service
 - (3) For members transitioning from a nursing facility to the community, the number of members authorized to receive a transition allowance as a CEA, the total amount of transition allowances authorized, the average transition allowance authorized
 - (4) A summary of items purchased with a transition allowance, including the most frequent categories of expenditure
 - (5) The number and percent of members authorized to receive other non-covered HCBS as a CEA

- (6) A summary of other non-covered HCBS authorized as a CEA, identifying the most frequently authorized services

2.30.17 Information Systems Reports

- 2.30.17.1 The CONTRACTOR shall submit an annual *Systems Refresh Plan* on December 1 for the upcoming year that meets the requirements in Section 2.23.1.6.
- 2.30.17.2 The CONTRACTOR shall submit *Encounter Data Files* in a standardized format as specified by TENNCARE (see Section 2.23.4) and transmitted electronically to TENNCARE on a weekly basis.
- 2.30.17.3 The CONTRACTOR shall provide an electronic version of a reconciliation between the amount paid as captured on the CONTRACTOR's encounter file submissions and the amount paid as reported by the CONTRACTOR in the 'CMS 1450 Claims Triangle' and 'CMS 1500 Claims Triangle' that accompanies the monthly Medical Fund Target report (see Section 2.30.15.2.1). In the event of any variances, the CONTRACTOR shall submit a written explanation accompanied by a 'CMS 1450 Claims Triangle' by category of service and a 'CMS 1500 Claims Triangle' by category of service, as applicable, to substantiate the explanation of the variance and identify the categories of services to which the variance is attributable. In the event that TENNCARE requires further detail of the variances listed, the CONTRACTOR shall provide any other data as requested by TENNCARE. This information shall be submitted with the Medical Fund Target report.
- 2.30.17.4 The CONTRACTOR shall provide any information and/or data requested in a format to be specified by TENNCARE as required to support the validation, testing or auditing of the completeness and accuracy of encounter data submitted by the CONTRACTOR.
- 2.30.17.5 The CONTRACTOR shall submit a monthly *Systems Availability and Performance Report* that provides information on availability and unavailability by major system as well as response times for the CONTRACTOR's Confirmation of MCO Enrollment and Electronic Claims Management functions, as measured within the CONTRACTOR's span of control.
- 2.30.17.6 The CONTRACTOR shall submit a baseline *Business Continuity and Disaster Recovery (BC-DR)* plan for review and written approval as specified by TENNCARE. The CONTRACTOR shall communicate proposed modifications to the BC-DR plan at least fifteen (15) calendar days prior to their proposed incorporation. Such modifications shall be subject to review and written approval by TENNCARE.

2.30.18 Administrative Requirements Reports

- 2.30.18.1 The CONTRACTOR shall submit a semi-annual *Report on the Activities of the CONTRACTOR's Behavioral Health Advisory Committee* regarding the activities of the behavioral health advisory committee established pursuant to Section 2.24.2. These reports shall be submitted to TENNCARE on March 1 and September 1 of each year.
- 2.30.18.2 Upon enrollment of members in CHOICES Group 2 and/or 3 (if and when directed by TENNCARE to serve as a back-up health plan and/or enroll members in

CHOICES Group 2 and/or 3), the CONTRACTOR shall submit a semi-annual *Report on the Activities of the CHOICES Advisory Group* regarding the activities of the CHOICES advisory group established pursuant to Section 2.24.3. This report shall include the membership of the advisory group (name, address, and organization represented), a description of any orientation and/or ongoing training activities for advisory group members, and information on advisory group meetings, including the date, time, location, meeting attendees, and minutes from each meeting. These reports shall be submitted to TENNCARE on March 1 and September 1 of each year.

2.30.19 Subcontract Reports

2.30.19.1 If the CONTRACTOR has subcontracted claims processing for TennCare claims, the CONTRACTOR shall provide to TENNCARE a Type II examination based on the Statement on Auditing Standards (SAS) No. 70, Service Organizations for each non-affiliated organization processing claims that represent more than twenty percent (20%) of TennCare medical expenses of the CONTRACTOR. This report shall be performed by an independent auditor (“service auditor”) and shall be due annually on May 1 for the preceding year operations or portion thereof.

2.30.19.2 In a Type II report, the service auditor will express an opinion on (1) whether the service organization’s description of its controls presents fairly, in all material respects, the relevant aspects of the service organization’s controls that had been placed in operation as of a specific date, and (2) whether the controls were suitably designed to achieve specified control objectives, and (3) whether the controls that were tested were operating with sufficient effectiveness to provide reasonable, but not absolute, assurance that the control objectives were achieved during the period specified. The audit of control activities over information and technology related processes related to TennCare claims processing by the subcontractor should include the following:

2.30.19.2.1 *General Controls*

2.30.19.2.1.1 Personnel Policies

2.30.19.2.1.2 Segregation of Duties

2.30.19.2.1.3 Physical Access Controls

2.30.19.2.1.4 Hardware and System Software

2.30.19.2.1.5 Applications System Development and Modifications

2.30.19.2.1.6 Computer Operations

2.30.19.2.1.7 Data Access Controls

2.30.19.2.1.8 Contingency and Business Recovery Planning

2.30.19.2.2 *Application Controls*

2.30.19.2.2.1 Input

2.30.19.2.2.2 Processing

2.30.19.2.2.3 Output

2.30.19.2.2.4 Documentation Controls

2.30.20 HIPAA Reports

The CONTRACTOR shall submit a *Privacy/Security Incident Report*. This report shall be provided at least annually, but the CONTRACTOR shall provide the report more frequently if requested by TENNCARE. The report shall include, at a minimum, the date of the incident, the date of notification to TENNCARE's privacy officer, the nature and scope of the incident, the CONTRACTOR's response to the incident, and the mitigating measures taken by the CONTRACTOR to prevent similar incidents in the future. "Port scans" or other unsuccessful queries to the CONTRACTOR's information system shall not be considered a privacy/security incident for purposes of this report.

2.30.21 Non-Discrimination Compliance Reports

2.30.21.1 On an annual basis the CONTRACTOR shall submit a copy of the CONTRACTOR's non-discrimination policy that demonstrates non-discrimination in the provision of services to members. The policy shall demonstrate non-discrimination in the provision of services for members with Limited English Proficiency and those requiring communication assistance in alternative formats. This shall include a report that lists all interpreter/translator services used by the CONTRACTOR in providing services to members with Limited English Proficiency or that need communication assistance in an alternative format. The listing shall identify the provider by full name, address, phone number, languages spoken, and hours services are available.

2.30.21.2 The CONTRACTOR shall submit an annual *Summary Listing of Servicing Providers* that includes race or ethnic origin of each provider. The listing shall include, at a minimum, provider name, address, race or ethnic origin and shall be sorted by provider type (e.g., pediatrician, surgeon, etc.). The CONTRACTOR shall use the following race or ethnic origin categories: American Indian or Alaskan Native, Asian or Pacific Islander, Hispanic origin and other race/ethnic origin as indicated by TENNCARE.

2.30.21.3 The CONTRACTOR shall annually submit its *Non-Discrimination Compliance Plan* and *Assurance of Non-Discrimination* to TENNCARE. The signature date of the CONTRACTOR's Plan shall coordinate with the signature date of the CONTRACTOR's Assurance of Non-Discrimination.

2.30.21.4 The CONTRACTOR shall submit a quarterly *Non-discrimination Compliance Report* which shall include the following:

2.30.21.4.1 A summary listing totaling the number of supervisory personnel by race or ethnic origin and sex. This report shall provide the number of male supervisors who are White, Black (not of Hispanic origin), American Indian or Alaskan Native, Asian or Pacific Islander, Hispanic origin and other race/ethnicity as indicated by

TENNCARE and number of female supervisors who are White, Black (not of Hispanic origin), American Indian or Alaskan Native, Asian or Pacific Islander, Hispanic origin and other race/ethnic origin females as indicated by TENNCARE:

2.30.21.4.2 A listing of all complaints filed by employees, members, providers and subcontractors in which discrimination is alleged related to the provision of and/or access to TennCare covered services provided by the CONTRACTOR. Such listing shall include, at a minimum, the identity of the party filing the complaint, the complainant's relationship to the CONTRACTOR, the circumstances of the complaint, date complaint filed, the CONTRACTOR's resolution, if resolved, and the name of the CONTRACTOR staff person responsible for adjudication of the complaint; and

2.30.21.4.3 A listing of all member requests for language and communication assistance. The report shall list the member, the member's identification number, the date of the request, the date the service was provided and the name of the service provider.

2.30.22 Terms and Conditions Reports

2.30.22.1 Quarterly, by January 30, April 30, July 30, and October 30 each year the CONTRACTOR shall make written disclosure regarding conflict of interest that includes the elements in Section 5.19.

2.30.22.2 Pursuant to Section 5.34.2, on a semi-annual basis the CONTRACTOR shall submit the attestation in Attachment X.

2.30.22.3 The CONTRACTOR shall maintain documentation that demonstrates the cost effectiveness of any non-covered services that are provided to TennCare enrollees and for which the CONTRACTOR seeks reimbursement from the State. A report summarizing all such documentation for the preceding year shall be submitted by the CONTRACTOR no later than sixty (60) calendar days after the end of each state fiscal year.

34. Section 3 shall be deleted in its entirety and replaced with the following:

SECTION 3 - REQUIREMENTS FOR CHILDREN IN STATE CUSTODY

The CONTRACTOR agrees to be the designated MCO carve-out entity for the delivery of services to children in State custody. The CONTRACTOR further agrees that at such time that any plan for children in State custody is provided and/or approved by the court, the CONTRACTOR shall administer this Agreement in accordance with the requirements of the court order. In the event that TENNCARE makes a determination that the requirements of the court order differ materially from the requirements specified in this Agreement, TENNCARE and the CONTRACTOR agree to negotiate the required amendments to this Agreement for the purpose of incorporating the requirements of the court order. TENNCARE and the CONTRACTOR recognize and agree that said amendment shall reflect mutually agreed upon additional costs to the CONTRACTOR, if any, related to the requirements of the court order, which must be documented by the CONTRACTOR and approved by TENNCARE, for which TENNCARE will compensate the CONTRACTOR. Children in State custody are eligible for the same TennCare covered services as other TennCare eligible children, in accordance with their TennCare eligibility status (TennCare Medicaid or TennCare Standard). However, due to the special needs of this population, this

Section specifies special requirements for the delivery of TennCare covered services for children who are eligible for participation in the carve-out.

3.1 CONTRACTOR RESPONSIBILITIES

3.1.1 General

Responsibilities for the administration and operation of the plan for the provision of services to children in State custody are assigned to several parties (e.g., the Steering Panel, the Implementation Team, the Department of Children's Services, Centers of Excellence for children in or at risk of State custody, Dental Benefits Manager, TennCare and delivery system providers). The CONTRACTOR agrees to arrange for services and administer the plan in collaboration with these other entities as described by TennCare. The CONTRACTOR agrees to:

- 3.1.1.1 Comply with any plan for children in State custody which has been provided and/or approved by the court on a schedule determined to be reasonable and in accordance with the requirements of the court.
- 3.1.1.2 Participate on the Children with Special Health Needs (CSHN) Steering Panel.
- 3.1.1.3 Recruit and contract with an adequate number of providers for Best Practice Network (BPN) with expertise in children's health problems in accordance with TennCare standards and the criteria of the plan for children in State custody and any subsequent plan for Children in State custody which has been provided and/or approved by the court.
- 3.1.1.4 Recruit for areas identified by the Implementation Team as having an inadequate network; contract with qualified and willing providers identified by the Implementation Team for areas (geographical or specialty) where a shortage is identified.
- 3.1.1.5 Develop procedures for assigning children in State custody to BPN providers; work with the Steering Panel to develop the best policy and mechanism for maintaining a long standing relationship between a child and a PCP, when family along with providers or the state feel that disruption of this relationship would be detrimental to the child. This is especially critical for children with severe physical or behavioral problems with a long-term relationship with the provider.
- 3.1.1.6 The CONTRACTOR agrees to implement and monitor provider use of best practice guidelines which have been drafted by the Center(s) of Excellence for children in or at risk of State custody in collaboration with the committee appointed by the Steering Panel.
- 3.1.1.7 Continue to manage and be responsible for all aspects of the TennCare program as specified in contracts with TennCare. Distribute Best Practice Guidelines to Best Practice Network providers when approved by the Steering Panel.
- 3.1.1.8 Work with state to develop those services determined to be necessary by CSHN Steering Panel.
- 3.1.1.9 Provide BPN-PCPs with a listing of behavioral health providers.

3.1.1.10 Educate BPN-PCPs on medical management policies and coordination of care requirements.

3.1.1.11 Ensure submission of encounter data from Best Practice Network providers.

3.1.2 Administration and Management

3.1.2.1 Staff Requirements

A specific Department of Children's Services (DCS) liaison person or persons shall be identified, in writing, to TENNCARE and the DCS. The DCS liaison person(s) will be responsible for assisting DCS to assure compliance with TENNderCare requirements and the coordination of care for children in custody and at prolonged risk of custody and shall support Best Practice Network Primary Care Providers (BPN-PCPs) as requested. The names, titles, addresses and contact numbers (phone, fax, etc.) shall be provided for each of the liaison persons to TENNCARE, DCS and BPN-PCPs. The liaison person(s) shall be available to TENNCARE and/or the DCS case managers, BPN-PCPs, and foster families for assistance. The number of specific liaison persons identified shall be adequate at all times to cover the number of children in or at prolonged risk of State custody enrolled in TennCare Select. Any staff changes in the identified liaison person(s) shall be reported in writing to TENNCARE and DCS within ten (10) calendar days of the change. BPN-PCPs shall be notified of any staff changes at least quarterly.

3.1.2.2 TENNCARE will coordinate the responsibility for training the DCS liaison(s) on issues dealing with the provision of TENNderCare services to children in or at prolonged risk of State custody. The liaisons will assist DCS with care coordination for these children and will have the responsibility of facilitating the timely delivery of TENNderCare services covered by the MCO. Assistance with care coordination will include identifying providers, scheduling appointments, and coordinating transportation (if appropriate), when requested.

3.1.3 Provider Network

3.1.3.1 Adequate Capacity

The CONTRACTOR must maintain a provider network with adequate capacity to deliver covered services that meet the special needs of children in State custody. Indicators of an adequate network include:

3.1.3.1.1 The CONTRACTOR meets the guidelines established by its contract with TENNCARE for a provider network (as specified in Section 2 and Section 3);

3.1.3.1.2 The CONTRACTOR has sufficient types and numbers of providers to be able to consistently deliver services in a timely manner when ordered for a child; and

3.1.3.1.3 The CONTRACTOR has within its network specialized health providers with sufficient expertise to deliver the covered services specified in this Agreement recognized in the Best Practice Guidelines as being proven effective and needed by children in State custody.

3.1.3.2 Provider Network Composition

In addition to maintaining a provider network in accordance with Section 2 of this Agreement, the CONTRACTOR shall maintain under contract, a Best Practice Network of providers including primary care physicians, medical sub specialists, and centers of excellence specifically engaged to serve children in State custody as specified below.

3.1.3.3 Coordination of Dental Services

The TennCare Dental Benefits Manager shall assume responsibility for the provision and payment of dental benefits for children in State custody. However, the CONTRACTOR shall agree to provide assistance with the coordination of dental services to children in State custody.

3.1.3.4 Best Practice Network Primary Care Providers

3.1.3.4.1 The CONTRACTOR shall maintain a Best Practice Network of Primary Care Providers (BPN-PCPs) who are community pediatricians and family practice physicians who agree to provide care timely and manage all health care including coordination of referrals for needed assessments or subspecialty care and serve as an advocate for children in custody to assure they get appropriate care. Specifically, BPN-PCPs must agree to:

3.1.3.4.1.1 Provide TENNderCare screenings timely if requested by DCS Case Managers;

3.1.3.4.1.2 Provide not only basic health care services, but also care coordination of all the health care services of children in custody;

3.1.3.4.1.3 Refer to physical health and behavioral health professionals in the Best Practice Network for specialty care; refer to the Center of Excellence for Children in, or at risk, of State custody, Community Mental Health Center when indicated; coordinate referrals when indicated with MCO;

3.1.3.4.1.4 Request telephone consultations with the Center of Excellence when indicated;

3.1.3.4.1.5 Communicate with caregivers on plan of care;

3.1.3.4.1.6 Maintain all health information on children assigned to them, regardless of who provides the care (Center of Excellence for children in, or at risk of, State custody, local specialist, behavioral health provider, other health care providers);

3.1.3.4.1.7 Report to DCS Health Unit any time health information on a child is not forwarded in a timely manner to allow for appropriate evaluation and care;

3.1.3.4.1.8 Forward medical files to newly assigned PCP and provide an initial consult when child is being transferred to a new geographical area or new MCO;

3.1.3.4.1.9 Share health information with DCS and foster parents within confidentiality guidelines;

- 3.1.3.4.1.10 Forward pertinent information to providers seeing child on referral;
- 3.1.3.4.1.11 Utilize (and document usage) of Best Practice Guidelines for care when developed and adopted by the Steering Panel. Document rationale for variation from Best Practice Guidelines;
- 3.1.3.4.1.12 Review information provided by state or MCO on caring for children in State custody;
- 3.1.3.4.1.13 Participate in the evaluation of system and outcomes through representation on the CSHN Steering Panel;
- 3.1.3.4.1.14 Participate in the MCO selected for children in custody;
- 3.1.3.4.1.15 Participate in training related to health problems of children in custody or Best Practice Guidelines; and
- 3.1.3.4.1.16 Develop health treatment plans and incorporate all treatment needs of the children they see.
- 3.1.3.4.2 The BPN-PCPs must also agree to perform the following case management functions:
 - 3.1.3.4.2.1 Maintenance of all health information on children including behavioral health and long-term care;
 - 3.1.3.4.2.2 Coordinate health services and request assistance from DCS case manager in following up and assuring plan of care is implemented;
 - 3.1.3.4.2.3 Consult with the Center of Excellence or other behavioral health providers when additional help is needed in managing a case; and
 - 3.1.3.4.2.4 Notify DCS when he/she feels more intense case management is needed by DCS.
- 3.1.3.4.3 The CONTRACTOR must insure that each DCS custody child is assigned to a Best Practice Network Primary Care Provider within thirty days of enrollment. However, if a child has an established relationship with a provider who is not in the Best Practice Network, but is willing to continue care for this child and is qualified and competent to provide the care, the CONTRACTOR will allow the PCP to continue to provide care and reimburse the provider for care at the same rate as Best Practice Network Providers, if requested by DCS or the child's legal guardian.
- 3.1.3.4.4 The CONTRACTOR may penalize BPN-PCPs who do not comply with the required responsibilities specified in paragraph 3.1.3.4.1.above. Any penalty to be assessed must be described in writing in the BPN-PCP's provider agreement and must be approved by the State.
- 3.1.3.4.5 When the State develops an internet based system for health providers to track medical information for children in State custody, the CONTRACTOR shall assist with provider education efforts on the system and amend its BPN-PCP Agreements to require BPN-PCPs to input required information into the system.

3.1.3.5 Centers of Excellence for Children in or at Risk of State Custody

The CONTRACTOR shall maintain contracts with all sites in the state recognized as Centers of Excellence for children in or at risk of State custody (which includes tertiary pediatric care): Johnson City, Knoxville, Chattanooga, Nashville and Memphis. It is the State's intent to recognize these centers via a contract that acknowledges the State's designation of each qualified facility as a Center of Excellence. The CONTRACTOR shall maintain contracts with each of these centers specifically for the provision of services to children in or at risk of State custody specified in the contract between the State and the COE.

3.1.3.6 Pediatric Sub-Specialists

The CONTRACTOR shall establish and maintain a network of pediatric sub-specialists in each of the five catchment areas in the state (Johnson City, Knoxville, Chattanooga, Nashville and Memphis) that includes each type of pediatric sub-specialist with admitting privileges at the catchment area tertiary pediatric center.

3.1.4 **Safety-Net**

3.1.4.1 TENNderCare – Physical Health Screenings

The CONTRACTOR shall include Local Health Departments in their provider network for the provision of TENNderCare services.

3.1.4.2 TENNderCare – Dental Screenings

3.1.4.2.1 Local Health Departments, in which dental services are available, will provide safety net services. Whenever the dental network is inadequate and dental care is urgent, the Dental Benefits Manager shall arrange for an out-of-network provider to provide the care.

3.1.4.2.2 Effective October 1, 2002, the TennCare Dental Benefits Manager shall assume responsibility for the provision and payment of dental benefits. However, CONTRACTOR shall agree to cooperate and participate with any subsequent plan for Children in State custody which has been provided and/or approved by the court.

3.1.5 **Provider Agreement Language**

The CONTRACTOR shall include in its subcontracts and agreements with providers a provision which states that subcontractors and providers are not permitted to encourage or suggest, in writing or verbally, that TennCare children be placed into State custody in order to receive medical, behavioral, or long-term care services covered by TennCare.

3.1.6 **Network Management**

3.1.6.1 Provider Education

The CONTRACTOR shall train the Best Practice Network on the roles and responsibilities of Best Practice Network Providers, including the requirement to use Best Practice Guidelines and maintain complete medical records, in accordance with the requirements listed at 3.1.3.4.

3.1.6.2 Monitoring

The CONTRACTOR shall conduct a medical chart review two times over the course of the original eighteen months of this Agreement and once in calendar year 2003 of a statistically valid sample of each BPN provider's medical charts to document Best Practice Network provider compliance with the requirements of the plan for children in State custody and any subsequent plan related to the provision of services to children in State custody of which the provider received advance notice, including the use of Best Practice Guidelines and completion of all seven required components of initial TENNderCare exams (or documentation explaining any reasons for not adhering to the guidelines or completing the seven components of the exam) for those cases where the BPN provider conducted the TENNderCare exam. The sampling methodology employed must be approved by TENNCARE prior to use.

3.1.6.3 Provider Profiling

The CONTRACTOR shall profile BPN-PCPs. Provider profiling for the Best Practice Network shall include the activities specified in Section 2.14.9 of this Agreement.

3.1.7 **BPN Training**

The CONTRACTOR shall require Best Practice Network provider participation in training sessions provided by the Center of Excellence and disseminate training materials to Best Practice Network providers as requested. Participation in training may be by teleconference, interactive Internet program, or in-person. The CONTRACTOR shall develop a survey to be administered after each training session designed to solicit feedback on barriers to attendance from non-participating providers. The CONTRACTOR shall provide an analysis of the findings and recommendations for increasing participation within ninety days of the training session.

3.1.8 **Service Delivery Requirements**

In addition to satisfying the requirements of Section 2 of this Agreement for the delivery of services, the CONTRACTOR shall meet the following requirements for the delivery of services to children in State custody:

3.1.8.1 Failure to Maintain Adequate Capacity in Network and Recruitment of Best Practice Network Providers

The CONTRACTOR shall recruit Best Practice Network providers who have appropriate credentials, are willing to follow BPN guidelines and are willing to participate in its network. DCS will report any incidences where providers are not

available to deliver services in a timely manner to both the Implementation Team and TENNCARE. The IT will keep records and report to TENNCARE in what areas of the state an inadequate network exists. The CONTRACTOR will be notified when reports indicate a network deficiency and when recruitment of additional providers is necessary.

3.1.8.2 Mental Health and Substance Abuse Services

In addition to the requirements specified in Section 2.6.1, the following requirements shall pertain to the coordination of mental health and substance abuse services for children in State custody:

- 3.1.8.2.1 The CONTRACTOR shall not limit the types or number of behavioral services that may be provided by a Best Practice Network Primary Care Provider.
- 3.1.8.2.2 Prior approval shall not be required by the CONTRACTOR in order for a Best Practice Network Primary Care Provider to refer children in State custody to a behavioral health provider.
- 3.1.8.2.3 The CONTRACTOR shall provide a listing of credentialed BPN-PCPs to behavioral health providers periodically to facilitate coordination of care.

3.1.8.3 Service Authorization

At such time that a procedure is implemented and described by TENNCARE, the Implementation Team shall be contacted for disposition when a covered service has been requested by a health care provider for a child in or at risk of State custody, and the CONTRACTOR denies or otherwise fails timely to provide that service or approve a less intense service which the provider or DCS feels is inadequate. Effective upon receipt of any plan for children in State custody which has been provided and/or approved by the court, the role of the Implementation Team may be modified.

3.1.8.4 Services While Transitioning Out of Custody

- 3.1.8.4.1 Children transitioning out of State custody shall continue to have access to Best Practice Network providers for a minimum period of six months unless specified otherwise by TENNCARE. The child transitioning out of State custody will remain in the CONTRACTOR's MCO and the CONTRACTOR will continue to provide services in accordance with this Agreement, or any plan for Children in State custody which has been provided and/or approved by the court, unless the child's legal guardian elects for the child to receive services outside of the Best Practice Network. All services for "children in State custody" in this Agreement are applicable to children transitioning out of State custody for the time period specified by TENNCARE, which shall be six months unless otherwise specified by TENNCARE.

3.1.8.4.2 When a child goes home for a 90-day trial but is still in State custody, this will count for the first three months of transition time. The above services can also be continued for an additional number of months to be specified by TENNCARE, which shall be six months unless otherwise specified by TENNCARE, on a case by case basis for a total of 365 days from the time of custody termination for those children whom DCS or the PCP and the Implementation Team deem it appropriate to prevent them from returning to State custody.

3.1.8.5 Children at Prolonged Risk of State Custody

Children that are deemed to be at prolonged risk of custody (to be defined by the Steering Panel) and that are identified to the CONTRACTOR by the state may continue to receive services through the Best Practice Network indefinitely.

3.1.9 **Reporting Requirements**

3.1.9.1 After the initial assignment of children in State custody to TennCare Select, the CONTRACTOR shall submit to the State a report that identifies the name of each DCS child enrolled in TennCare Select, the child's ID number, the date the child was placed in State custody, the date the CONTRACTOR received notice of enrollment, and the date of the child's initial TENNderCare exam, updated on a monthly basis, excluding children in transition.

3.1.9.2 For enrollees who have been assigned Immediate Eligibility, the CONTRACTOR shall, after twenty-five (25) calendar days of Immediate Eligibility coverage, identify children whose Immediate Eligibility will end in twenty (20) calendar days to the DCS Program Coordinator of Health Advocacy.

3.1.10 **Performance Guarantees**

The CONTRACTOR agrees to be bound by the performance guarantees identified below for the duration of this Agreement.

3.1.10.1 Provider Training Participation

3.1.10.1.1 BPN provider training participation at least once a year by teleconference, interactive internet program or in-person.

3.1.9.1.2

Penalty for Non-compliance:	\$25,000 for failure to timely complete training survey as specified in Section 3.1.6
Measurement:	Timely submission of survey findings

3.2 **DEPARTMENT OF CHILDREN'S SERVICES RESPONSIBILITIES**

The Department of Children's Services shall be responsible for the following requirements related to the responsibilities of the CONTRACTOR:

3.2.1 Notify the CONTRACTOR when a child enters State custody so that Immediate Eligibility can be established.

- 3.2.2 Maintain responsibility of seeing that children in custody receive appropriate health services, including arranging appointments timely for TENNderCare screenings to be performed at the local health department.
- 3.2.3 Report on number of children receiving TENNderCare screenings in timely fashion.
- 3.2.4 Provide care coordination and case management consistent with the John B Consent Decree and state and federal Medicaid regulations.
- 3.2.5 Provide a representative to the CSHN Steering Panel.
- 3.2.6 Provide training to staff to carry out the components of this plan.
- 3.2.7 Provide medical information to child's assigned PCP in a timely manner and ensure follow up care is done by the PCP for any problems identified during the child's TENNderCare screening.

3.3 TENNCARE BUREAU RESPONSIBILITIES

The TennCare Bureau shall be responsible for the following:

- 3.3.1 Contract with the carve-out MCO, with a statewide network that has expertise for children's physical, developmental and behavioral problems to provide care management services to children in State custody and children at "prolonged risk" of State custody (to be defined by the Steering Panel) using fee for service structure and an arrangement which decreases the financial risk for the MCO.
- 3.3.2 Contract with the COE for any services needed to implement this plan (for child psychiatrist, training, other functions as negotiated)
- 3.3.3 Require MCO to provide adequate encounter and financial data to determine the provided services and the cost of those services for children in State custody.
- 3.3.4 Provide resources for staffing the CSHN Steering Panel and Implementation Team.
- 3.3.5 Participate on the CSHN Steering Panel.
- 3.3.6 Require the MCO to include in its provider agreements and subcontracts with providers a provision which states that the providers/subcontractors are forbidden from encouraging or suggesting, in writing or verbally, TennCare children be placed into State custody to receive medical or behavioral treatments. But instead, they are to let families know that there are other options and refer them to the Implementation Team when they are unable to get behavioral health services and are at risk of coming into custody.
- 3.3.7 Develop a process whereby children who are already enrolled in TennCare but may not be assigned to the custodial MCO will be reassigned as soon as TENNCARE has been informed that the child is in State custody or is at risk of State custody and should be placed in the custodial MCO. TENNCARE shall comply with any subsequent plan for Children in State custody which has been provided and/or approved by the court.

3.4 IMPLEMENTATION TEAM

The Implementation Team shall:

- 3.4.1 Review MCO denials or delays for services and issue letter of authorization for those services it determines to be appropriate under the circumstances at such time that policies and procedures are established by TENNCARE.
- 3.4.2 The Implementation Team is expressly granted access to the medical records (physical, behavioral, and long-term care) of those children the Implementation Team is required to assist. All of the medical records obtained by the Implementation Team shall be held in the strictest confidence, and shall not be released to any individual unless the requesting individual is expressly granted such access by law, or unless the Implementation Team is ordered to release them by a court of competent jurisdiction.
- 3.4.3 Determine when children referred to them are at imminent risk of custody and need additional services provided to this group to prevent custody. (DCS will still perform this service also.)
- 3.4.4 Identify areas where provider networks are inadequate from the problems the team experiences in obtaining services for children at risk of custody as well as those in custody. Recommend to MCOs (both for the custody children and the other children in TennCare) where networks are inadequate.

3.5 DEPARTMENT OF HEALTH

The Department of Health, through the local county health departments shall be responsible for the following:

- 3.5.1 Ensure that they can meet the timeframe of offering DCS children an appointment for an TENNderCare screening within 21 days of request by DCS, but not to exceed thirty (30) days of placement in State custody.
- 3.5.2 Provide a letter to the DCS Case Manager and the child's assigned primary care provider confirming whether all seven components of the TENNderCare screening were completed and stating any concerns that should be referred to the primary care provider for follow up.
- 3.5.3 Provide the DCS Case Manager and the child's assigned primary care provider a letter stating the results of any lab tests performed on the child.

35. Section 4.1.1 shall be amended by deleting the reference to "Attachment XVI" and replacing it with "Attachment XII".

36. Section 4.1.5 shall be amended by (1) deleting the reference to "Attachment XVI" and replacing it with "Attachment XII" and (2) deleting the reference to "Attachment XIII" and replacing it with "Attachment IX".

37. Section 4.1 shall be amended by inserting a new Sub-Section 4.1.7, which shall read as follows:

4.1.7 Administrative fee payments made in accordance with Section 4.1.1, 4.1.2, and Attachment XII will not include payment for care coordination to CHOICES members. TENNCARE will make a separate payment for the costs associated with the provision of care coordination to CHOICES members upon receipt of an invoice from the CONTRACTOR. The invoice shall be submitted to TENNCARE in the form and format specified by TENNCARE.

38. Section 4.2 shall be deleted and replaced as follows:

4.2 PAY-FOR-PERFORMANCE QUALITY INCENTIVE PAYMENTS

4.2.1 General

4.2.1.1 TENNCARE will make incentive payments to the CONTRACTOR in accordance with this Section 4.2.

4.2.1.2 The TennCare Select HEDIS score for the previous calendar year for each of the measures specified in Sections 4.2.2 and 4.2.3.2 will serve as the baseline rate in the NCQA minimum effect size change calculations (see Section 4.2.4 below).

4.2.1.3 If NCQA makes changes in any of the measures specified in Section 4.2.2 or 4.2.3 below, such that valid comparison to prior years will not be possible, TENNCARE, at its sole discretion, may elect to either eliminate the measure from pay-for-performance incentive eligibility or replace it with another measure.

4.2.2 Physical Health HEDIS Measures

4.2.2.1 Beginning on July 1, 2010, on July 1 of each year, the CONTRACTOR will be eligible for a \$.03 PMPM payment, applied to member months from the preceding calendar year, for each of the audited HEDIS measures specified in Section 4.2.2.2 below (calculated from the preceding calendar year's data) for which significant improvement has been demonstrated. Significant improvement is defined using NCQA's minimum effect size change methodology (see Section 4.2.4 below).

4.2.2.2 Incentive payments will be available for the following audited HEDIS measures:

4.2.2.2.1 Appropriate Treatment for Children with Upper Respiratory Infection (URI);

4.2.2.2.2 Childhood Immunization Status - MMR;

4.2.2.2.3 Children and Adolescents' Access to PCP – 7-11 year old age group;

4.2.2.2.4 Children and Adolescents' Access to PCP – 12-19 year old age group;

4.2.2.2.5 Well Child Visits – 3rd, 4th, 5th and 6th years of life; and

4.2.2.2.6 Adolescent Well Care Visits.

4.2.3 Behavioral Health HEDIS Measures

4.2.3.1 On July 1 of 2011, the CONTRACTOR will be eligible for a \$.03 PMPM payment, applied to member months from the preceding calendar year, for each of the following audited HEDIS measures (calculated from the preceding calendar year’s data) for which the CONTRACTOR scores at or above the 75th national Medicaid percentile, as calculated by NCQA. To be eligible for incentive payment for a measure, the CONTRACTOR must score at or above the 75th percentile for both rates comprising the measure.

4.2.3.1.1 Follow-up After Hospitalization for Mental Illness; and

4.2.3.1.2 Follow-up Care for Children Prescribed ADHD Medication.

4.2.3.2 Beginning on July 1, 2012, on July 1 of each year, the CONTRACTOR will be eligible for a \$.03 PMPM payment, applied to member months from the preceding calendar year, for each of the audited HEDIS measures specified in Section 4.2.3 below (calculated from the preceding calendar year’s data) for which significant improvement has been demonstrated. To be eligible for incentive payment for a measure, the CONTRACTOR must demonstrate significant improvement for both rates comprising the measure. Significant improvement is defined using NCQA’s minimum effect size change methodology (see Section 4.2.4 below).

4.2.3.2.1 Follow-up After Hospitalization for Mental Illness; and

4.2.3.2.2 Follow-up Care for Children Prescribed ADHD Medication.

4.2.4 NCQA Minimum Effect Size Change Methodology

The NCQA minimum effect size change methodology is as follows:

Baseline Rate	Minimum Effect Size
0-59	At least a 6 percentage point change
60-74	At least a 5 percentage point change
75-84	At least a 4 percentage point change
85-92	At least a 3 percentage point change
93-96	At least a 2 percentage point change
97-99	At least a 1 percentage point change

39. Section 4.3.2.1 shall be amended by deleting “EPSDT” and replacing it with “TENnderCare”.

40. Sections 4.3.5 and 4.3.6 shall be amended by deleting references to “EPSDT” and replacing them with references to “TENnderCare”.

41. Section 4 shall be amended by inserting a new Sub-Section 4.4 and renumbering the existing Sub-Sections accordingly, including any references thereto. The new Sub-Section 4.4 shall read as follows:

4.4 Effect of Disenrollment on Administrative Fee Payments

4.4.1 Payment of the administrative fee shall cease effective the date of the member's disenrollment from the CONTRACTOR's MCO, and the CONTRACTOR shall have no further responsibility for the care of the enrollee. Except for situations involving enrollment obtained by fraudulent applications or death, disenrollment from TennCare shall not be made retroactively. The CONTRACTOR shall not be required to refund any administrative fee amounts legitimately paid pursuant to this Agreement.

4.4.2 Fraudulent Enrollment

4.4.2.1 In the case of fraudulent, misrepresented or deceptive applications submitted by the enrollee, the CONTRACTOR, at its discretion, may refund to TENNCARE all administrative fee payments made on behalf of persons who obtained enrollment in TennCare through such means and the CONTRACTOR may pursue full restitution for all payments made on behalf of the individual while the person was inappropriately enrolled in the CONTRACTOR's MCO.

4.4.2.2 In the event of enrollment obtained by fraud, misrepresentation or deception by the CONTRACTOR's staff, officers, employees, providers, volunteers, subcontractors, or anyone acting for or on behalf of the CONTRACTOR, TENNCARE may retroactively recover administrative fee payments and medical services payments plus interest as allowed by TCA 47-14-103, and HMO payments and any other monies paid to the CONTRACTOR for the enrollment of that individual. The refund of administrative fee and medical services payments plus interest and HMO payments will not preclude the State from exercising its right to criminal prosecution, civil penalties, trebled damages and/or other remedial measures.

42. Section 4 shall be amended by inserting a new Sub-Section 4.6 and renumbering the existing Sub-Sections accordingly, including any references thereto. The new Sub-Section 4.6 shall read as follows:

4.6 PAYMENT TO THE CONTRACTOR FOR ELECTRONIC VISIT VERIFICATION SYSTEM

TENNCARE will pay the CONTRACTOR \$605,600 to offset the CONTRACTOR's costs related to implementing an electronic visit verification (EVV) system. In accordance with the applicable appropriations language, these funds shall be used to implement the EVV, and they shall not be used for any other purpose. Upon TENNCARE's request the CONTRACTOR shall submit documentation that demonstrates that funds were used to offset the CONTRACTOR's costs related to implementing the EVV.

43. Renumbered Section 4.7 shall be deleted and replaced as follows:

4.7 PAYMENTS TO CONTRACTOR

The administrative fee payments, the premium tax payments, and any incentive payments (if applicable), and any payments that offset the CONTRACTOR's cost for the development and implementation of an electronic visit verification system (EVV) (see Section 4.6) specified in Section 4 and Attachment XII of this Agreement as amended, shall represent payment in full. TennCare shall not reimburse CONTRACTOR for any costs, liquidated damages and/or penalties incurred by the CONTRACTOR and which result from actions or inactions, including penalties associated with CONTRACTOR's failure to timely pay any and all expenses, fees, taxes and other regulatory/ministerial costs associated with the requirements of operating as an HMO in this state. The taxes, fees, expenses, and other regulatory/ministerial costs referenced herein shall include but not be limited to premium taxes associated with any and all obligations required by the Tennessee Health Maintenance Organization Act of 1986 codified at TCA 56-32-101 *et seq.* or any subsequent amendments thereto and/or the Tennessee Prepaid Limited Health Services Act of 2000 codified at TCA 56-51-101 *et seq.* or any subsequent amendments thereto.

44. Renumbered Section 4.8.1 shall be deleted and replaced as follows:

4.8.1 In no event shall the maximum liability of the State under this Agreement during the original term of the Agreement exceed ONE BILLION EIGHT HUNDRED THIRTY MILLION NINE HUNDRED NINETY THOUSAND FIVE HUNDRED AND FIVE DOLLARS AND NINETY CENTS (\$1,830,990,505.90).

45. Section 5 shall be amended by deleting Section 5 in its entirety and replacing it with the following and renumbering all references thereto:

SECTION 5 - TERMS AND CONDITIONS

5.1 NOTICE

All notices required to be given under this Agreement shall be given in writing, and shall be sent by United States certified mail, postage prepaid, return receipt requested; in person; or by other means, so long as proof of delivery and receipt is given, and the cost of delivery is borne by the notifying party, to the appropriate party at the address given below, or at such other address (or addresses) as may be provided by notice given under this Section.

If to TENNCARE:

Deputy Commissioner
Bureau of TennCare
310 Great Circle Rd
Nashville, Tennessee 37243

If to the CONTRACTOR:

Sonya Nelson
President and Chief Executive Officer
Volunteer State Health Plan, Inc.

801 Pine Street
Chattanooga, TN 37402-2555

5.2 AGREEMENT TERM

- 5.2.1 This Agreement, and its incorporated attachments, if any, as well as all Amendments to this Agreement, contain all of the terms and conditions agreed upon by the parties, and when executed by all parties, supersedes any prior agreements. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall be in effect from July 1, 2001, subject to approval by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The term of this Agreement shall expire on June 30, 2011. At the mutual agreement of TENNCARE and the CONTRACTOR, this Agreement shall be renewable for an additional twelve month period.
- 5.2.2 Notwithstanding any provision herein to the contrary, the State may terminate this Agreement if the waiver governing TennCare is terminated. The documents referenced in the Agreement are on file with the CONTRACTOR and with TENNCARE and the CONTRACTOR is aware of their content. No other agreement, oral or otherwise regarding the subject matter of this Agreement, shall be deemed to exist or to bind any of the parties hereto.

5.2.3 Exigency Extension

At the option of the State, the CONTRACTOR agrees to continue services under this Agreement when TENNCARE determines that there is a public exigency that requires the services to continue. Continuation of services pursuant to this Section shall be in three (3) month increments and the total of all public exigency extensions shall not exceed twelve (12) months. Thirty (30) days notice shall be given by TENNCARE before this option is exercised. TENNCARE shall reimburse the CONTRACTOR during exigency at the established administrative fee in effect during the last six (6) months of this Agreement.

5.3 APPLICABLE LAWS AND REGULATIONS

The CONTRACTOR agrees to comply with all applicable federal and state laws, rules and regulations, policies (including TennCare Standard Operating Procedures (so long as said TennCare Standard Operating Procedure does not constitute a material change to the obligations of the CONTRACTOR pursuant to this Agreement)), consent decrees, and court orders, including Constitutional provisions regarding due process and equal protection of the law, including but not limited to:

- 5.3.1 42 CFR Chapter IV, Subchapter C (with the exception of those parts waived under the TennCare Section 1115(a) waiver).
- 5.3.2 45 CFR Part 74, General Grants Administration Requirements.
- 5.3.3 Titles 4, 47, 56, and 71, Tennessee Code Annotated, including, but not limited to, the TennCare Drug Formulary Accountability Act, Public Chapter 276 and The Standardized Pharmacy Benefit Identification Card Act.
- 5.3.4 All applicable standards, orders, or regulations issued pursuant to the Clean Air Act of 1970 (42 USC 7401, *et seq.*).

Amendment Number 22 (cont.)

- 5.3.5 Title VI of the Civil Rights Act of 1964 (42 USC 2000d) and regulations issued pursuant thereto, 45 CFR Part 80.
- 5.3.6 Title VII of the Civil Rights Act of 1964 (42 USC 2000e) in regard to employees or applicants for employment.
- 5.3.7 Section 504 of the Rehabilitation Act of 1973, 29 USC 794, which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting from federal financial assistance, and regulations issued pursuant thereto, 45 CFR Part 84.
- 5.3.8 The Age Discrimination Act of 1975, 42 USC 6101 *et seq.*, which prohibits discrimination on the basis of age in programs or activities receiving or benefiting from federal financial assistance.
- 5.3.9 The Omnibus Budget Reconciliation Act of 1981, P.L. 97-35, which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefiting from federal financial assistance.
- 5.3.10 Americans with Disabilities Act, 42 USC 12101 *et seq.*, and regulations issued pursuant thereto, 28 CFR Parts 35, 36.
- 5.3.11 Sections 1128 and 1156 of the Social Security Act relating to exclusion of providers for fraudulent or abusive activities involving the Medicare, SCHIP and/or Medicaid program.
- 5.3.12 The Church Amendments (42 U.S.C. 300a-7).
- 5.3.13 Section 245 of the Public Health Service (PHS) Act (42 U.S.C. 238n).
- 5.3.14 Weldon Amendment (Consolidated Appropriations Act 2008, Public Law 110-161, Div. G, Sec. 508 (d), 121 Stat. 1844, 2209).
- 5.3.15 Tennessee Consumer Protection Act, TCA 47-18-101 *et seq.*
- 5.3.16 The TennCare Section 1115 waiver and all Special Terms and Conditions which relate to the waiver.
- 5.3.17 Executive Orders, including Executive Order 1 effective January 26, 1995 and Executive Order 3 effective February 3, 2003.
- 5.3.18 The Clinical Laboratory Improvement Amendments (CLIA) of 1988.
- 5.3.19 Requests for approval of material modification as provided at TCA 56-32-101 *et seq.*
- 5.3.20 Investigatory Powers of TDCI pursuant to TCA 56-32-132.
- 5.3.21 42 USC 1396 *et seq.* (with the exception of those parts waived under the TennCare Section 1115(a) waiver).
- 5.3.22 The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Section 1171(5)(E) of the Social Security Act as enacted by HIPAA.
- 5.3.23 Title IX of the Education Amendments of 1972 regarding education programs and activities.

Amendment Number 22 (cont.)

- 5.3.24 Title 42 CFR 422.208 and 210, Physician Incentive Plans.
- 5.3.25 Equal Employment Opportunity (EEO) Provisions.
- 5.3.26 Copeland Anti-Kickback Act.
- 5.3.27 Davis-Bacon Act.
- 5.3.28 Contract Work Hours and Safety Standards.
- 5.3.29 Rights to Inventions Made Under a Contract or Agreement.
- 5.3.30 Byrd Anti-Lobbying Amendment.
- 5.3.31 Subcontracts in excess of one hundred thousand dollars (\$100,000) shall require compliance with all applicable standards, orders or requirements issued under Section 306 of the Clean Air Act (42 USC 1857 (h)), Section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR Part 15).
- 5.3.32 Mandatory standards and policies relating to energy efficiency which are contained in the state energy conservation plan issued in compliance with the Energy Policy and Conservation Act (P.L. 94-165).
- 5.3.33 TennCare Reform Legislation signed May 11, 2004.
- 5.3.34 Federal Pro-Children Act of 1994 and the Tennessee Children's Act for Clean Indoor Air of 1995.
- 5.3.35 Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2.
- 5.3.36 Title 33 (Mental Health Law) of the Tennessee Code Annotated.
- 5.3.37 Rules of the Tennessee Department of Mental Health and Developmental Disabilities, Rule 0940 *et seq.*
- 5.3.38 Section 1902(a)(68) of the Social Security Act regarding employee education about false claims recovery.
- 5.3.39 TennCare rules and regulations.
- 5.3.40 TCA 3-6-101 *et seq.*, 3-6-201 *et seq.*, 3-6-301 *et seq.*, and 8-50-505.
- 5.3.41 TCA 71-6-101 *et seq.*
- 5.3.42 TCA 37-1-401 *et seq.* and 37-1-601 *et seq.*
- 5.3.43 TCA 68-11-1001 *et seq.*
- 5.3.44 TCA 71-5-1401 *et seq.*

5.4 TERMINATION

In the event of termination, it is agreed that neither party shall be relieved from any financial obligations each may owe to the other as a result of liabilities incurred during the course of this Agreement. For terminations pursuant to Sections 5.4.1, 5.4.2, 5.4.3, 5.4.4, or 5.4.6, TENNCARE will assume responsibility for informing all affected enrollees of the reasons for their termination from the CONTRACTOR's MCO.

5.4.1 Termination Under Mutual Agreement

Under mutual agreement, TENNCARE and the CONTRACTOR may terminate this Agreement for any reason if it is in the best interest of TENNCARE and the CONTRACTOR. Both parties will sign a notice of termination which shall include, inter alia, the date of termination, conditions of termination, and extent to which performance of work under this Agreement is terminated.

5.4.2 Termination by TENNCARE for Cause

5.4.2.1 The CONTRACTOR shall be deemed to have breached this Agreement if any of the following occurs:

5.4.2.1.1 The CONTRACTOR fails to perform in accordance with any term or provision of the Agreement;

5.4.2.1.2 The CONTRACTOR only renders partial performance of any term or provision of the Agreement; or

5.4.2.1.3 The CONTRACTOR engages in any act prohibited or restricted by the Agreement.

5.4.2.2 For purposes of Section 5.4.2, items 5.4.2.1.1 through 5.4.2.1.3 shall hereinafter be referred to as "Breach."

5.4.2.3 In the event of a Breach by the CONTRACTOR, TENNCARE shall have available any one or more of the following remedies in addition to or in lieu of any other remedies set out in this Agreement or available in law or equity:

5.4.2.3.1 Recover actual damages, including incidental and consequential damages, and any other remedy available at law or equity;

5.4.2.3.2 Require that the CONTRACTOR prepare a plan to immediately correct cited deficiencies, unless some longer time is allowed by TENNCARE, and implement this correction plan;

5.4.2.3.3 Recover any and/or all liquidated damages provided in Section 5.20.2; and

5.4.2.3.4 Declare a default and terminate this Agreement.

5.4.2.4 In the event of a conflict between any other Agreement provisions and Section 5.4.2.3, Section 5.4.2.3 shall control.

5.4.2.5 In the event of Breach by the CONTRACTOR, TENNCARE may provide the CONTRACTOR written notice of the Breach and twenty (20) calendar days to cure

the Breach described in the notice. In the event that the CONTRACTOR fails to cure the Breach within the time period provided, then TENNCARE shall have available any and all remedies described herein and available at law.

- 5.4.2.6 In the event the CONTRACTOR disagrees with the determination of noncompliance or designated corrective action described in the notice, the CONTRACTOR shall nevertheless implement said corrective action, without prejudice to any rights the CONTRACTOR may have to later dispute the finding of noncompliance or designated corrective action.

5.4.3 Termination for Unavailability of Funds

In the event that federal and/or state funds to finance this Agreement become unavailable, TENNCARE may terminate the Agreement immediately in writing to the CONTRACTOR without penalty. The CONTRACTOR shall be entitled to receive and shall be limited to, just and equitable compensation for any satisfactory authorized work performed as of the termination date. Availability of funds shall be determined solely by TENNCARE.

5.4.4 Termination Due to Change in Ownership

- 5.4.4.1 In the event that an entity that contracts with TENNCARE to provide the covered services of this Agreement in the same Grand Region(s) as the CONTRACTOR has or acquires an indirect ownership interest or an ownership or control interest (as defined in 42 CFR Part 455, Subpart B) in the CONTRACTOR, TENNCARE may terminate this Agreement immediately in writing to the CONTRACTOR without penalty. The CONTRACTOR will be entitled to reimbursement under the Agreement provisions regarding mutual termination in Section 5.4.1.

- 5.4.4.2 In the event that the CONTRACTOR has or acquires an indirect ownership interest or an ownership or control interest (as defined in 42 CFR Part 455, Subpart B) of an entity that contracts with TENNCARE to provide the covered services of this Agreement in the same Grand Region(s) as the CONTRACTOR, TENNCARE may terminate this Agreement immediately in writing to the CONTRACTOR without penalty. The CONTRACTOR will be entitled to reimbursement under the Agreement provisions regarding mutual termination in Section 5.4.1.

- 5.4.4.3 If an entity that contracts with TENNCARE to provide the covered services of this Agreement in the same Grand Region(s) as the CONTRACTOR proposes to acquire an indirect ownership interest or an ownership or control interest (as defined in 42 CFR Part 455, Subpart B) in the CONTRACTOR, or the CONTRACTOR proposes to acquire an indirect ownership interest or an ownership or control interest (as defined in 42 CFR Part 455, Subpart B) in an entity that contracts with TENNCARE to provide covered services of this Agreement in the same Grand Region(s) as the CONTRACTOR, the CONTRACTOR shall notify TENNCARE and shall provide TENNCARE with regular updates regarding the proposed acquisition.

5.4.5 Termination for CONTRACTOR Financial Inviability, Insolvency or Bankruptcy

- 5.4.5.1 If TENNCARE reasonably determines that the CONTRACTOR's financial condition is not sufficient to allow the CONTRACTOR to provide the services as described herein in the manner required by TENNCARE, TENNCARE may terminate this

Agreement in whole or in part, immediately or in stages. Said termination shall not be deemed a Breach by either party. The CONTRACTOR's financial condition shall be presumed not sufficient to allow the CONTRACTOR to provide the services described herein in the manner required by TENNCARE if the CONTRACTOR can not demonstrate to TENNCARE's satisfaction that the CONTRACTOR has risk reserves and a net worth to meet the applicable net worth requirement specified in Section 2.21.5 of this Agreement.

5.4.5.2 CONTRACTOR insolvency or the filing of a petition in bankruptcy by or against the CONTRACTOR shall constitute grounds for termination for cause. In the event of the filing of a petition in bankruptcy by or against a principal subcontractor or provider or the insolvency of said subcontractor or provider, the CONTRACTOR shall immediately advise TENNCARE.

5.4.6 **Termination by TENNCARE for Convenience**

TENNCARE may terminate this Agreement for convenience and without cause upon thirty (30) calendar days written notice. Said termination shall not be a Breach of the Agreement by TENNCARE, and TENNCARE shall not be responsible to the CONTRACTOR or any other party for any costs, expenses, or damages occasioned by said termination, i.e., without penalty.

5.4.7 **Termination Procedures**

5.4.7.1 The party initiating the termination shall render written notice of termination to the other party by certified mail, return receipt requested, or in person with proof of delivery. The notice of termination shall specify the provision of this Agreement giving the right to terminate, the circumstances giving rise to termination, and the date on which such termination shall become effective.

5.4.7.2 Upon receipt of notice of termination, and subject to the provisions of this Section, on the date and to the extent specified in the notice of termination, the CONTRACTOR shall:

5.4.7.2.1 Stop work under the Agreement, but not before the termination date;

5.4.7.2.2 At the point of termination, assign to TENNCARE in the manner and extent directed by TENNCARE all the rights, title and interest of the CONTRACTOR for the performance of the subcontracts to be determined at need in which case TENNCARE shall have the right, in its discretion, to settle or pay any of the claims arising out of the termination of such agreements and subcontracts;

5.4.7.2.3 Complete the performance of such part of the Agreement that shall have not been terminated under the notice of termination;

5.4.7.2.4 Take such action as may be necessary, or as a contracting officer may direct, for the protection of property related to this Agreement which is in possession of the CONTRACTOR and in which TENNCARE has or may acquire an interest;

5.4.7.2.5 Continue to submit invoices for the payment of covered services as specified in Section 4. One hundred eighty days after the Agreement ends, the CONTRACTOR shall reasonably estimate the amount of claims remaining to be paid for covered

services provided during the Agreement period that were not reflected in the final invoice. If TENNCARE accepts the estimate as reasonable, TENNCARE will deposit that amount in an account for the purpose of paying run-out claims. TennCare will supplement the funding of the account as necessary to permit coverage of the remaining payable claims as needed;

- 5.4.7.2.6 In the event the Agreement is terminated by TENNCARE, continue to serve or arrange for provision of services to the enrollees in the CONTRACTOR's MCO for up to forty-five (45) calendar days from the Agreement termination date or until the members can be transferred to another MCO, whichever is longer. During this transition period, TENNCARE shall continue to pay the applicable administrative fee, medical payments and HMO payments as specified in Section 4 of this Agreement;
- 5.4.7.2.7 Promptly make available to TENNCARE, or another MCO acting on behalf of TENNCARE, any and all records, whether medical, behavioral, related to long-term care services or financial, related to the CONTRACTOR's activities undertaken pursuant to this Agreement. Such records shall be in a usable form and shall be provided at no expense to TENNCARE;
- 5.4.7.2.8 Promptly supply all information necessary to TENNCARE or another MCO acting on behalf of TENNCARE for reimbursement of any outstanding claims at the time of termination;
- 5.4.7.2.9 Submit a termination plan to TENNCARE for review, which is subject to TENNCARE written approval. This plan shall, at a minimum, contain the provisions in Sections 5.4.8.2.10 through 4.4.8.2.15 below. The CONTRACTOR shall agree to make revisions to the plan as necessary in order to obtain approval by TENNCARE. Failure to submit a termination plan and obtain written approval of the termination plan by TENNCARE shall result in the withhold of 25% of the CONTRACTOR's monthly administrative fee payment as described in Section 4;
- 5.4.7.2.10 Agree to maintain claims processing functions as necessary for a minimum of nine (9) months (or longer if it is likely there are additional claims outstanding) in order to complete adjudication of all claims. During this period, medical payments and HMO payments shall continue to be paid as specified in Section 4;
- 5.4.7.2.11 Agree to comply with all duties and/or obligations incurred prior to the actual termination date of the Agreement, including but not limited to, the appeal process as described in Section 2.19;
- 5.4.7.2.12 File all reports concerning the CONTRACTOR's operations during the term of the Agreement in the manner described in this Agreement;
- 5.4.7.2.13 Take whatever other actions are necessary in order to ensure the efficient and orderly transition of members from coverage under this Agreement to coverage under any new arrangement developed by TENNCARE;
- 5.4.7.2.14 In order to ensure that the CONTRACTOR fulfills its continuing obligations both before and after termination, maintain the financial requirements (as described in this Agreement as of the CONTRACTOR's date of termination notice), fidelity bonds

and insurance set forth in this Agreement until the State provides the CONTRACTOR written notice that all continuing obligations of this Agreement have been fulfilled; and

5.4.7.2.15 Upon expiration or termination of this Agreement, submit reports to TENNCARE every thirty (30) calendar days detailing the CONTRACTOR's progress in completing its continuing obligations under this Agreement. The CONTRACTOR, upon completion of these continuing obligations, shall submit a final report to TENNCARE describing how the CONTRACTOR has completed its continuing obligations. TENNCARE shall within twenty (20) calendar days of receipt of this report advise in writing whether TENNCARE agrees that the CONTRACTOR has fulfilled its continuing obligations. If TENNCARE finds that the final report does not evidence that the CONTRACTOR has fulfilled its continuing obligations, then TENNCARE shall require the CONTRACTOR to submit a revised final report. TENNCARE shall in writing notify the CONTRACTOR once the CONTRACTOR has submitted a revised final report evidencing to the satisfaction of TENNCARE that the CONTRACTOR has fulfilled its continuing obligations.

5.5 ENTIRE AGREEMENT

5.5.1 This Agreement, including any amendments or attachments, represents the entire Agreement between the CONTRACTOR and TENNCARE with respect to TennCare Select, and supersedes all other contracts between the parties with regard to the provision of services described herein. Any communications made before the parties entered into this Agreement, whether verbal or in writing, shall not be considered as part of or explanatory of any part of this Agreement.

5.5.2 In the event of a conflict of language between the Agreement and any amendments, the provisions of the amendments shall govern.

5.5.3 All applicable state and federal laws, rules and regulations, consent decrees, court orders and policies and procedures (hereinafter referred to as Applicable Requirements), including those described in Section 5.3 of this Agreement are incorporated by reference into this Agreement. Any changes in those Applicable Requirements shall be automatically incorporated into this Agreement by reference as soon as they become effective.

5.6 INCORPORATION OF ADDITIONAL DOCUMENTS

5.6.1 Included in this Agreement by reference are the following documents:

5.6.1.1 The Agreement document and its attachments, as defined in Section 5.5 above;

5.6.1.2 All clarifications and addenda made to the CONTRACTOR's Proposal;

5.6.1.3 The Request for Proposal and its associated amendments;

5.6.1.4 Technical Specifications provided to the CONTRACTOR; and

5.6.1.5 The CONTRACTOR's Proposal.

5.6.2 In the event of a discrepancy or ambiguity regarding the CONTRACTOR's duties, responsibilities, and performance under this Agreement, these documents shall govern in order of precedence detailed above.

5.7 APPLICABILITY OF THIS AGREEMENT

All terms, conditions, and policies stated in this Agreement apply to staff, agents, officers, subcontractors, providers, volunteers and anyone else acting for or on behalf of the CONTRACTOR.

5.8 TECHNICAL ASSISTANCE

Technical assistance shall be provided to the CONTRACTOR when deemed appropriate by TENNCARE.

5.9 PROGRAM INFORMATION

Upon request, TENNCARE shall provide the CONTRACTOR complete and current information with respect to pertinent statutes, regulations, rules, policies, procedures, and guidelines affecting the CONTRACTOR's operation pursuant to this Agreement.

5.10 QUESTIONS ON POLICY DETERMINATIONS

On an ongoing basis, should the CONTRACTOR have a question on policy determinations, benefits or operating guidelines, the CONTRACTOR shall request a determination from TENNCARE in writing. The State shall have thirty (30) calendar days to make a determination and respond unless specified otherwise. Should TENNCARE not respond in the required amount of time, the CONTRACTOR shall not be penalized as a result of implementing items awaiting approval. However, failure to respond timely shall not preclude the State from requiring the CONTRACTOR to respond or modify the policy or operating guideline prospectively. The CONTRACTOR shall be afforded at least sixty (60) calendar days to implement the modification.

5.11 INTERPRETATIONS

Any dispute between the CONTRACTOR and TENNCARE concerning the clarification, interpretation and application of all federal and state laws, regulations, or policy or consent decrees or court orders governing or in any way affecting this Agreement shall be determined by TENNCARE. When a clarification, interpretation and application is required, the CONTRACTOR shall submit a written request to TENNCARE. TENNCARE will contact the appropriate agencies in responding to the request by submitting the written request to the agency within thirty (30) calendar days after receiving that request from the CONTRACTOR. Any clarifications received pursuant to requests for clarification, interpretation and application shall be forwarded upon receipt to the CONTRACTOR. Nothing in this Section shall be construed as a waiver by the CONTRACTOR of any legal right it may have to contest the findings of either the state or federal governments or both as they relate to the clarification, interpretation and application of statute, regulation, or policy or consent decrees or court orders.

5.12 CONTRACTOR APPEAL RIGHTS

The CONTRACTOR must have the right to contest TENNCARE decisions pursuant to the provisions of TCA 9-8-301 *et seq.* for the resolution of disputes under this Agreement. Written notice describing the substance and basis of the contested action shall be submitted to TENNCARE within thirty (30) calendar days of the action taken by TENNCARE. The CONTRACTOR shall comply with all requirements contained within this Agreement pending the final resolution of the contested action.

5.13 DISPUTES

Any claim by the CONTRACTOR against TENNCARE arising out of the breach of this Agreement shall be handled in accordance with the provision of TCA 9-8-301, *et seq.* Provided, however, the CONTRACTOR agrees that the CONTRACTOR shall give notice to TENNCARE of its claim thirty (30) calendar days prior to filing the claim in accordance with TCA 9-8-301, *et seq.*

5.14 NOTIFICATION OF LEGAL ACTION AGAINST THE CONTRACTOR

The CONTRACTOR shall give TENNCARE and TDCI immediate notification in writing by certified mail (or other means such as overnight delivery reasonably designed to document delivery) within five (5) business days of the CONTRACTOR being served with any administrative or legal action or complaint filed regarding any claim in law or equity made against the CONTRACTOR or an affiliate of the CONTRACTOR (including but not limited to a parent company), that would materially impact either such affiliate's ability to operate its business or the CONTRACTOR's performance of duties hereunder. The CONTRACTOR shall also provide similar notice of any arbitration proceedings instituted between a provider and the CONTRACTOR. The CONTRACTOR shall ensure that all tasks related to the provider agreement are performed in accordance with the terms of this Agreement. It is the intent of this provision that the CONTRACTOR notify TENNCARE of any and all actions described herein that may affect the CONTRACTOR's financial viability and/or program operations or integrity.

5.15 DATA THAT MUST BE CERTIFIED

5.15.1 In accordance with 42 CFR 438.604 and 438.606, when State payments to the CONTRACTOR are based on data submitted by the CONTRACTOR, the CONTRACTOR shall certify the data. The data that shall be certified include, but are not limited to, enrollment information, encounter data, and other information required by the State and contained in contracts, proposals and related documents including the Medical Fund Target report. The data shall be certified by one of the following: the CONTRACTOR's Chief Executive Officer, the CONTRACTOR's Chief Financial Officer, or an individual who has delegated authority to sign for, and who reports directly to the CONTRACTOR's Chief Executive Officer or Chief Financial Officer. The certification shall attest, based on best knowledge, information, and belief, as follows:

5.15.1.1 To the accuracy, completeness and truthfulness of the data; and

5.15.1.2 To the accuracy, completeness and truthfulness of the documents specified by the State.

5.15.2 The CONTRACTOR shall submit the certification concurrently with the certified data.

5.16 USE OF DATA

TENNCARE shall have unlimited but not exclusive rights to use, disclose, or duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by the CONTRACTOR resulting from this Agreement. However, TENNCARE shall not disclose proprietary information that is afforded confidential status by state or federal law.

5.17 WAIVER

No covenant, condition, duty, obligation, or undertaking contained in or made a part of this Agreement may be waived except by written agreement of the Agreement signatories or in the event the signatory for a party is no longer empowered to sign such Agreement, the signatory's replacement. Forbearance, forgiveness, or indulgence in any other form or manner by either party in any regard whatsoever shall not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed, or discharged by the party to which the same may apply. Until complete performance or satisfaction of all such covenants, conditions, duties, obligations, or undertakings, the other party shall have the right to invoke any remedy available under law or equity notwithstanding any such forbearance, forgiveness or indulgence.

5.18 AGREEMENT VARIATION/SEVERABILITY

If any provision of this Agreement (including items incorporated by reference) is declared or found to be illegal, unenforceable, or void, then both TENNCARE and the CONTRACTOR shall be relieved of all obligations arising under such provision. If the remainder of the Agreement is capable of performance, it shall not be affected by such declaration of finding and shall be fully performed. In addition, if the laws or regulations governing this Agreement should be amended or judicially interpreted as to render the fulfillment of the Agreement impossible or economically unfeasible, both TENNCARE and the CONTRACTOR will be discharged from further obligations created under the terms of the Agreement.

5.19 CONFLICT OF INTEREST

5.19.1 The CONTRACTOR warrants that no part of the total Agreement amount provided herein shall be paid directly, indirectly or through a parent organization, subsidiary or an affiliate organization to any state or federal officer or employee of the State of Tennessee or any immediate family member of a state or federal officer or employee of the State of Tennessee as wages, compensation, or gifts in exchange for acting as officer, agent, employee, subcontractor, or consultant to the CONTRACTOR in connection with any work contemplated or performed relative to this Agreement unless disclosed to the Commissioner, Tennessee Department of Finance and Administration. For purposes of Section 5.19 and its subparts of this contract, "immediate family member" shall mean a spouse or minor child(ren) living in the household.

5.19.1.1 Quarterly, by January 30, April 30, July 30, and October 30 each year, or at other times or intervals as designated by the Deputy Commissioner of the Bureau of TennCare, disclosure shall be made by the CONTRACTOR to the Deputy Commissioner of the Bureau of TennCare, Department of Finance and Administration in writing. The disclosure shall include, but not be limited to, the following:

- 5.19.1.1.1 A list of any state or federal officer or employee of the State of Tennessee as well as any immediate family member of a state or federal officer or employee of the State of Tennessee who receives wages or compensation from the CONTRACTOR; and
- 5.19.1.1.2 A statement of the reason or purpose for the wages or compensation.

The disclosures shall be made by the CONTRACTOR and reviewed by TENNCARE in accordance with Standard Operating Procedures and the disclosures shall be distributed to, amongst other persons, entities and organizations, the Commissioner, Tennessee Department of Finance and Administration, the Tennessee Ethics Commission, the TennCare Oversight Committee and the Fiscal Review Committee.

- 5.19.1.2 This Agreement may be terminated by TENNCARE and/or the CONTRACTOR may be subject to sanctions, including liquidated damages, under this Agreement if it is determined that the CONTRACTOR, its agents or employees offered or gave gratuities of any kind to any state or federal officials or employees of the State of Tennessee or any immediate family member of a state or federal officer or employee of the State of Tennessee if the offering or giving of said gratuity is in contravention or violation of state or federal law. It is understood by and between the parties that the failure to disclose information as required under Section 5.19 of this Agreement may result in termination of this Agreement and the CONTRACTOR may be subject to sanctions, including liquidated damages in accordance with Section 5.20 of this Agreement. The CONTRACTOR certifies that no member of or delegate of Congress, the United States General Accounting Office, DHHS, CMS, or any other federal agency has or will benefit financially or materially from this Agreement.

- 5.19.2 The CONTRACTOR shall include language in all subcontracts and provider agreements and any and all agreements that result from this Agreement between CONTRACTOR and TENNCARE to ensure that it is maintaining adequate internal controls to detect and prevent conflicts of interest from occurring at all levels of the organization. Said language may make applicable the provisions of Section 5.19 to all subcontracts, provider agreements and all agreements that result from the Agreement between the CONTRACTOR and TENNCARE.

5.20 FAILURE TO MEET AGREEMENT REQUIREMENTS

It is acknowledged by TENNCARE and the CONTRACTOR that in the event of CONTRACTOR's failure to meet the requirements provided in this Agreement and all documents incorporated herein, TENNCARE will be harmed. The actual damages which TENNCARE will sustain in the event of and by reason of such failure are uncertain, are extremely difficult and impractical to ascertain and determine. The parties therefore acknowledge that the CONTRACTOR shall be subject to damages and/or sanctions as described below. It is further agreed that the CONTRACTOR shall pay TENNCARE liquidated damages as directed by TENNCARE; provided however, that if it is finally determined that the CONTRACTOR would have been able to meet the Agreement requirements listed below but for TENNCARE's failure to perform as provided in this Agreement, the CONTRACTOR shall not be liable for damages resulting directly therefrom.

5.20.1 Intermediate Sanctions

- 5.20.1.1 TENNCARE may impose any or all of the sanctions as described in this Section upon TENNCARE's reasonable determination that the CONTRACTOR failed to comply with any corrective action plan (CAP) as described under Section 2.25.11 or Section 2.23.13 of this Agreement, or is otherwise deficient in the performance of its obligations under the Agreement, which shall include, but may not be limited to the following:
 - 5.20.1.1.1 Fails substantially to provide medically necessary covered services;
 - 5.20.1.1.2 Imposes on members cost sharing responsibilities that are in excess of the cost sharing permitted by TENNCARE;
 - 5.20.1.1.3 Acts to discriminate among enrollees on the basis of their health status or need for health care services;
 - 5.20.1.1.4 Misrepresents or falsifies information that it furnishes to CMS or to the State;
 - 5.20.1.1.5 Misrepresents or falsifies information that it furnishes to a member, potential member, or provider;
 - 5.20.1.1.6 Fails to comply with the requirements for physician incentive plans, as required by 42 CFR 438.6(h) and set forth (for Medicare) in 42 CFR 422.208 and 422.210;
 - 5.20.1.1.7 Has distributed directly, or indirectly through any agent or independent contractor, marketing or member materials that have not been approved by the State or that contain false or materially misleading information; and
 - 5.20.1.1.8 Has violated any of the other applicable requirements of Sections 1903(m) or 1932 of the Social Security Act and any implementing regulations.
- 5.20.1.2 TENNCARE shall only impose those sanctions it determines to be appropriate for the deficiencies identified. However, TENNCARE may impose intermediate sanctions on the CONTRACTOR simultaneously with the development and implementation of a corrective action plan if the deficiencies are severe and/or numerous. Intermediate sanctions may include:
 - 5.20.1.2.1 Liquidated damages as described in Section 5.20.2;
 - 5.20.1.2.2 Suspension of enrollment in the CONTRACTOR's MCO;
 - 5.20.1.2.3 Disenrollment of members;
 - 5.20.1.2.4 Limitation of the CONTRACTOR's service area;
 - 5.20.1.2.5 Civil monetary penalties as described in 42 CFR 438.704;
 - 5.20.1.2.6 Appointment of temporary management for an MCO as provided in 42 CFR 438.706;

- 5.20.1.2.7 Suspension of all new enrollment, including default enrollment, after the effective date of the sanction;
- 5.20.1.2.8 Suspension of payment for members enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur; or
- 5.20.1.2.9 Additional sanctions allowed under federal law or state statute or regulation that address areas of noncompliance.

5.20.2 **Liquidated Damages**

5.20.2.1 Reports and Deliverables

- 5.20.2.1.1 For each day that a report or deliverable is late, incorrect, or deficient, the CONTRACTOR shall be liable to TENNCARE for liquidated damages in the amount of one hundred dollars (\$100) per day per report or deliverable unless specified otherwise in this Section. Liquidated damages for late reports/deliverables shall begin on the first day the report/deliverable is late.
- 5.20.2.1.2 Liquidated damages for incorrect reports or deficient deliverables shall begin on the first day after the report/deliverable was due.
- 5.20.2.1.3 For the purposes of determining liquidated damages in accordance with this Section, reports or deliverables are due as specified elsewhere in this Agreement or by TENNCARE.

5.20.2.2 Program Issues

- 5.20.2.2.1 Liquidated damages for failure to perform specific responsibilities or requirements as described in this Agreement are shown in the chart below. Damages are grouped into three categories: **Level A**, **Level B**, and **Level C** program issues.
- 5.20.2.2.2 Failure to perform specific responsibilities or requirements categorized as **Level A** are those which pose a significant threat to patient care or to the continued viability of the TennCare program.
- 5.20.2.2.3 Failure to perform specific responsibilities or requirements categorized as **Level B** are those with pose threats to the integrity of the TennCare program, but which do not necessarily imperil patient care.
- 5.20.2.2.4 Failure to perform specific responsibilities or requirements categorized as **Level C** are those which represent threats to the smooth and efficient operation of the TennCare program but which do not imperil patient care or the integrity of the TennCare program.
- 5.20.2.2.5 TENNCARE may also assess liquidated damages for failure to meet performance standards as provided in Section 2.24.3, Attachment VII, and Attachment XI of this Agreement.

5.20.2.2.6 TENNCARE reserves the right to assess a general liquidated damage of five hundred dollars (\$500) per occurrence with any notice of deficiency.

5.20.2.2.7 *Liquidated Damages Chart*

LEVEL	PROGRAM ISSUES	DAMAGE
A.1	Failure to comply with claims processing as described in Section 2.22 of this Agreement	\$10,000 per month, for each month that TENNCARE determines that the CONTRACTOR is not in compliance with the requirements of Section 2.22 of this Agreement
A.2	Failure to comply with licensure and background check requirements in Section 2.29.2 and Attachment XI of this Agreement	\$5,000 per calendar day that staff/provider/driver/agent/subcontractor is not licensed or qualified as required by applicable state or local law plus the amount paid to the staff/provider/driver/agent/subcontractor during that period
A.3	Failure to respond to a request by DCS or TENNCARE to provide service(s) to a child in DCS custody or at risk of entering DCS custody	The actual amount paid by DCS and/or TENNCARE for necessary services or \$1,000, whichever is greater
A.4	Failure to comply with obligations and time frames in the delivery of TENNderCare screens and related services	The actual amount paid by DCS and/or TENNCARE for necessary services or \$1,000, whichever is greater
A.5	Denial of a request for services to a child in DCS custody or at risk of entering DCS custody when the services have been reviewed and authorized by the TENNCARE Chief Medical Officer	The actual amount paid by DCS and/or TENNCARE for necessary services or \$1,000, whichever is greater

LEVEL	PROGRAM ISSUES	DAMAGE
<p>A.6(a)</p>	<p>Failure to provide a service or make payments for a service within five (5) calendar days of a directive from TENNCARE (pursuant to an appeal) to do so, or upon approval of the service or payment by the CONTRACTOR during the appeal process, or within a longer period of time which has been approved by TENNCARE upon the CONTRACTOR's demonstration of good cause</p>	<p>\$500 per day beginning on the next calendar day after default by the CONTRACTOR in addition to the cost of the services not provided</p>
<p>A.6(b)</p>	<p>Failure to provide proof of compliance to TENNCARE within five (5) calendar days of a directive from TENNCARE or within a longer period of time which has been approved by TENNCARE upon the CONTRACTOR's demonstration of good cause</p>	<p>\$500 per day beginning on the next calendar day after default by the CONTRACTOR</p>
<p>A.7</p>	<p>Failure to comply with this Agreement and federal rules/law regarding Sterilizations/Abortions/Hysterectomies as outlined in Section 2.7.8 of this Agreement</p>	<p>\$500 per occurrence or the actual amount of the federal penalty created by the CONTRACTOR's failure to comply, whichever is greater</p>
<p>A.8</p>	<p>Failure to provide coverage for prenatal care without a delay in care and in accordance with Section 2.7.5 of this Agreement</p>	<p>\$500 per day, per occurrence, for each calendar day that care is not provided in accordance with the terms of this Agreement</p>

LEVEL	PROGRAM ISSUES	DAMAGE
A.9	Failure to provide continuation or restoration of services where enrollee was receiving the service as required by TENNCARE rules or regulations, applicable state or federal law, and all court orders and consent decrees governing appeal procedures as they become effective	An amount sufficient to at least offset any savings the CONTRACTOR achieved by withholding the services and promptly reimbursing the enrollee for any costs incurred for obtaining the services at the enrollee's expense \$500 per day for each calendar day beyond the 2 nd business day after an On Request Report regarding a member's request for continuation of benefits is sent by TENNCARE
A.10.(a)	Failure to comply with the notice requirements of this Agreement, TennCare rules and regulations, and all court orders and consent decrees governing appeal procedures, as they become effective	\$500 per occurrence in addition to \$500 per calendar day for each calendar day required notices are late or deficient or for each calendar day beyond the required time frame that the appeal is unanswered in each and every aspect and/or each day the appeal is not handled according to the provisions set forth by this Agreement or required by TENNCARE \$1,000 per occurrence if the notice remains defective plus a per calendar day assessment in increasing increments of \$500 (\$500 for the first day, \$1,000 for the second day, \$1,500 for the third day, etc.) for each day the notice is late and/or remains defective
A.10.(b)	Failure to submit a timely corrected notice of adverse action to TENNCARE for review and approval prior to issuance to the member	
A.11	Failure to forward an expedited appeal to TENNCARE in twenty-four (24) hours or a standard appeal in five (5) days	\$500 per calendar day
A.12	Failure to provide complete documentation, including medical records, and comply with the timelines for responding to a medical appeal as set forth in TennCare rules and regulations and all court orders and consent decrees governing appeals procedures as they become effective	\$500 per calendar day for each calendar day beyond the required time frame that the appeal is unanswered in each and every aspect and/or each day the appeal is not handled according to the provisions set forth by this Agreement or required by TENNCARE

LEVEL	PROGRAM ISSUES	DAMAGE
A.13	Per the Revised Grier Consent Decree, “Systemic problems or violations of the law” (e.g., a failure in 20% or more of appealed cases over a 60-day period) regarding any aspect of medical appeals processing pursuant to TennCare rules and regulations and all court orders and consent decrees governing appeal procedures, as they become effective	<p>First occurrence: \$500 per instance of such “systemic problems or violations of the law”, even if damages regarding one or more particular instances have been assessed (in the case of “systemic problems or violations of the law” relating to notice content requirements, \$500 per notice even if a corrected notice was issued upon request by TENNCARE)</p> <p>Damages per instance shall increase in \$500 increments for each subsequent “systemic problem or violation of the law” (\$500 per instance the first time a “systemic problem or violation of the law” relating to a particular requirement is identified; \$1,000 per instance for the 2nd time a “systemic problem or violation of the law” relating to the same requirement is identified; etc.)</p>
A.14	Failure to (1) provide an approved service timely, i.e., in accordance with timelines specified in this Agreement, or when not specified therein, with reasonable promptness; or (2) issue appropriate notice of delay with documentation upon request of ongoing diligent efforts to provide such approved service	The cost of services not provided plus \$500 per day, per occurrence, for each day (1) that approved care is not provided timely; or (2) notice of delay is not provided and/or the CONTRACTOR fails to provide upon request sufficient documentation of ongoing diligent efforts to provide such approved service
A.15	Failure to acknowledge or act timely upon a request for prior authorization in accordance with TennCare rules and regulations	The cost of services not provided plus \$500 per day, per occurrence, for each day that it is determined the CONTRACTOR failed to acknowledge or act timely upon a request for prior authorization in accordance with TennCare rules and regulations

LEVEL	PROGRAM ISSUES	DAMAGE
A.16	Failure to comply with the timeframes for developing and approving a plan of care for transitioning CHOICES members in CHOICES Group 2, authorizing and initiating nursing facility services for transitioning members in CHOICES Group 1, or initiating long-term care services for CHOICES members (see Sections 2.9.2, 2.9.3, and 2.9.6)	<p>\$5,000 per month that the CONTRACTOR's performance is 85-89% by service setting (nursing facility or HCBS)</p> <p>\$10,000 per month that the CONTRACTOR's performance is 80-84% by service setting (nursing facility or HCBS)</p> <p>\$15,000 per month that the CONTRACTOR's performance is 75-79% by service setting (nursing facility or HCBS)</p> <p>\$20,000 per month that the CONTRACTOR's performance is 70-74% by service setting (nursing facility or HCBS)</p> <p>\$25,000 per month that the CONTRACTOR's performance is 69% or less by service setting (nursing facility or HCBS)</p>
A.17	Failure to meet the performance standards established by TENNCARE regarding missed visits for personal care, attendant care, homemaker, or home-delivered meals (referred to herein as "specified HCBS") for members in CHOICES Group 2 or 3	<p>\$5,000 per month that 11-15% of visits are missed for a reason attributable to the provider (provider initiated), by specified HCBS</p> <p>\$10,000 per month that 16-20% of visits are missed for a reason attributable to the provider (provider initiated), by specified HCBS</p> <p>\$15,000 per month that 21-25% of visits are missed for a reason attributable to the provider (provider initiated), by specified HCBS</p> <p>\$20,000 per month that 26-30% of visits are missed for a reason attributable to the provider (provider initiated), by specified HCBS</p> <p>\$25,000 per month that 31% or more of visits are missed for a reason attributable to the provider (provider initiated), by specified HCBS</p>
B.1	Failure to provide referral provider listings to PCPs as required by Section 2.14.3.5 of this Agreement	\$500 per calendar day
B.2	Failure to complete or comply with corrective action plans as required by TENNCARE	\$500 per calendar day for each day the corrective action is not completed or complied with as required
B.3	Failure to submit Audited HEDIS and CAHPS results annually by June 15 as described in Sections 2.15.5 and 2.15.6	\$250 per day for every calendar day reports are late
B.4	Failure to submit NCQA Accreditation Report as described in Section 2.15.5	\$500 per day for every calendar day beyond the 10 th calendar day Accreditation Status is not reported

LEVEL	PROGRAM ISSUES	DAMAGE
B.5	Failure to comply with Conflict of Interest, Lobbying, and/or Gratuities requirements described in Section 5.19, 5.23, or 5.24, or 2.12.9.48	110% of the total amount of compensation paid by the CONTRACTOR to inappropriate individuals
B.6	Failure to disclose Lobbying Activities and/or quarterly conflict of interest disclosure as required by Section 5.24, 5.19, or 2.12.9.48	\$1,000 per day that disclosure is late
B.7	Failure to obtain approval of member materials as required by Section 2.17 of this Agreement	\$500 per day for each calendar day that TENNCARE determines the CONTRACTOR has provided member material that has not been approved by TENNCARE
B.8	Failure to comply with time frames for providing Member Handbooks, I.D. cards, Provider Directories, Quarterly Member Newsletters, and CHOICES member education materials as required in Section 2.17	\$5,000 for each occurrence
B.9	If the CONTRACTOR knew or should have known that a member has not received long-term care services for thirty (30) days or more, failure to report on that member in accordance with Section 2.30.10.5 (see also Section 2.6.1.5.7)	For each member, an amount equal to the administrative fee prorated for the period of time in which the member did not receive long-term care services
B.10	Failure to achieve and/or maintain financial requirements in accordance with TCA	\$500 per calendar day for each day that financial requirements have not been met
B.11	Failure to submit the CONTRACTOR's annual NAIC filing as described in Section 2.30.15.3	\$500 per calendar day
B.12	Failure to submit the CONTRACTOR's quarterly NAIC filing as described in Section 2.30.15.3	\$500 per calendar day

LEVEL	PROGRAM ISSUES	DAMAGE
B.13	Failure to submit audited financial statements as described in Section 2.30.15.3	\$500 per calendar day
B.14	Failure to comply with fraud and abuse provisions as described in Section 2.20 of this Agreement	\$500 per calendar day for each day that the CONTRACTOR does not comply with fraud and abuse provisions
B.15	Failure to send collection notices to providers as described in Section 2.30.9.6 of this Agreement	\$100 per provider notice per month
B.16	Failure to send detailed reports to TENNCARE as described in Sections 2.30.9.7 through 2.30.9.10 of this Agreement	\$500 per day for each day that report is late
B.17	Failure to require and ensure compliance with Ownership and Disclosure requirements as required in Section 2.12.9.60 of this Agreement	\$5,000 per provider disclosure/attestation for each disclosure/attestation that is not received or is received and signed by a provider that does not request or contain complete and satisfactory disclosure of the requirements outlined in 42 CFR 455, Subpart B
B.18	Failure to maintain a complaint and appeal system as required in Section 2.19 of this Agreement	\$500 per calendar day
B.19	Failure to comply with the timeframe for resolving complaints (see Section 2.19.2)	\$1,000 per month that the CONTRACTOR's performance is 85-89% \$2,000 per month that the CONTRACTOR's performance is 80-84% \$3,000 per month that the CONTRACTOR's performance is 75-79% \$4,000 per month that the CONTRACTOR's performance is 70-74% \$5,000 per month that the CONTRACTOR's performance is 69% or less
B.20	Failure to maintain required insurance as required in Section 2.21.8 of this Agreement	\$500 per calendar day

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LEVEL	PROGRAM ISSUES	DAMAGE
B.21	Failure to provide a written discharge plan or provision of a defective discharge plan for discharge from a psychiatric inpatient facility or mental health residential treatment facility as required in Section 2.9.9.3.2 of this Agreement	\$1,000 per occurrence per case
B.22	Imposing arbitrary utilization guidelines or other quantitative coverage limits as prohibited in Section 2.6.3 and 2.14.1 of this Agreement	\$500 per occurrence
B.23	Failure to provide CRG/TPG assessments within the time frames specified in Section 2.7.2.9 of this Agreement	\$500 per month per Enrollee
B.24	Failure to provide CRG/TPG assessments by TDMHDD-certified raters or in accordance with TDMHDD policies and procedures as required in Section 2.7.2.9 of this Agreement	\$500 per occurrence per case
B.25	Failure to meet any timeframe regarding care coordination for CHOICES members (see Sections 2.9.2, 2.9.3, and 2.9.6) other than the timeframes referenced in A.16 or A.17	\$1,000 per month for each timeframe that the CONTRACTOR's performance is 85-89% \$2,000 per month for each timeframe that the CONTRACTOR's performance is 80-84% \$3,000 per month for each timeframe that the CONTRACTOR's performance is 75-79% \$4,000 per month for each timeframe that the CONTRACTOR's performance is 70-74% \$5,000 per month for each timeframe that the CONTRACTOR's performance is 69% or less

LEVEL	PROGRAM ISSUES	DAMAGE
B.26	Failure to completely process a credentialing application within thirty (30) calendar days of receipt of a completed application, including all necessary documentation and attachments, and signed provider agreement/contract as required in Section 2.11.8 of this Agreement	<p>\$5,000 per application that has not been approved and loaded into the CONTRACTOR's system or denied within thirty (30) calendar days of receipt of a completed credentialing application and a signed provider agreement/contract if applicable</p> <p>And/Or</p> <p>\$1,000 per application per day for each day beyond thirty (30) calendar days that a completed credentialing application has not been processed as described in Section 2.11.8 of this Agreement</p>
B.27	Failure to maintain provider agreements in accordance with Section 2.12 and Attachment XI of this Agreement	\$5,000 per provider agreement found to be non-compliant with the requirements outlined in this Agreement
B.28	Failure to comply with the requirements regarding an agreement to audit accounts (Section 2.21.11)	\$1,500 for each day after December 1 of each year that the fully executed agreement for audit accounts is not submitted or for each day after December 1 of each year that the fully executed agreement does not include the required language
C.1	Failure to comply in any way with staffing requirements as described in Section 2.29.1 of this Agreement	\$250 per calendar day for each day that staffing requirements are not met
C.2	Failure to report provider notice of termination of participation in the CONTRACTOR's MCO	\$250 per day
C.3	Failure to comply in any way with encounter data submission requirements as described in Section 2.23 of this Agreement (excluding the failure to address or resolve problems with individual encounter records in a timely manner as required by TENNCARE)	\$25,000 per occurrence
C.4	Failure to address or resolve problems with individual encounter records in a timely manner as required by TENNCARE	An amount equal to the paid amount of the individual encounter record(s) that was rejected or, in the case of capitated encounters, the fee-for-service equivalent thereof as determined by TENNCARE

LEVEL	PROGRAM ISSUES	DAMAGE
C.5	Failure to reimburse the first MCO within thirty (30) calendar days of receipt of a properly documented request for a misaligned newborn in accordance with Section 2.4.9.5	\$1,000 per day for each day beyond thirty (30) calendar days of receipt of a properly documented request in addition to a one time assessment of \$5,000 per occurrence
C.6	Failure to comply with the requirements regarding documentation for CHOICES members (see Section 2.9.6)	\$500 per plan of care for members in CHOICES Group 2 or 3 that does not include all of the required elements \$500 per member file that does not include all of the required elements \$500 per face-to-face visit where the care coordinator fails to document the specified observations
C.7	Failure to submit a Provider Enrollment File that meets TENNCARE's specifications (see Section 2.30.7.1)	\$250 per day after the due date that the Provider Enrollment File fails to meet TENNCARE's specifications

5.20.2.3 Payment of Liquidated Damages

5.20.2.3.1 It is further agreed by TENNCARE and the CONTRACTOR that any liquidated damages assessed by TENNCARE shall be due and payable to TENNCARE within thirty (30) calendar days after CONTRACTOR receipt of the notice of damages. If payment is not made by the due date, said liquidated damages may be withheld from future administrative payments by TENNCARE without further notice. It is agreed by TENNCARE and the CONTRACTOR that the collection of liquidated damages by TENNCARE shall be made without regard to any appeal rights the CONTRACTOR may have pursuant to this Agreement; however, in the event an appeal by the CONTRACTOR results in a decision in favor of the CONTRACTOR, any such funds withheld by TENNCARE will be immediately returned to the CONTRACTOR. Any cure periods referenced in this Agreement shall not apply to the liquidated damages described in this Section. With respect to **Level B** and **Level C** program issues (failure to perform responsibilities or requirements), the due dates mentioned above may be delayed if the CONTRACTOR can show good cause as to why a delay should be granted. TENNCARE has sole discretion in determining whether good cause exists for delaying the due dates.

5.20.2.3.2 Liquidated damages as described in Section 5.20.2 shall not be passed to a provider and/or subcontractor unless the damage was caused due to an action or inaction of the provider and/or subcontractor. Nothing described herein shall prohibit a provider and/or a subcontractor from seeking judgment before an appropriate court in situations where it is unclear that the provider and/or the subcontractor caused the damage by an action or inaction.

5.20.2.3.3 All liquidated damages imposed pursuant to this Agreement, whether paid or due, shall be paid by the CONTRACTOR out of administrative and management costs and profits.

5.20.2.4 Application of Liquidated Damages for CHOICES

5.20.2.4.1 Unless and until directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, the liquidated damages in Section 5.20.2 specific to CHOICES Group 2 and/or 3, as determined by TENNCARE, will not apply. When directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, all of the liquidated damages in Section 5.20.2 shall apply.

5.20.2.4.2 In applying liquidated damages related to care coordination timeframes (see A.16 and B.25), HCBS missed visits (see A.17), and the CHOICES Utilization Report (see B.9) TENNCARE may take into consideration whether, as determined by TENNCARE, the CONTRACTOR promptly remedied a deficiency and/or a deficiency was due to circumstances beyond the CONTRACTOR's control. Such consideration shall be based on information provided by the CONTRACTOR in the applicable report (see Section 2.30) and/or additional information submitted by the CONTRACTOR as requested by TENNCARE.

5.20.2.5 Waiver of Liquidated Damages

TENNCARE may waive the application of liquidated damages upon the CONTRACTOR if the CONTRACTOR is placed in rehabilitation or under administrative supervision if TENNCARE determines that such waiver is in the best interests of the TennCare program and its enrollees.

5.20.3 Claims Processing Failure

If it is determined that there is a claims processing deficiency related to the CONTRACTOR's ability/inability to reimburse providers in a reasonably timely and accurate fashion as required by Section 2.22, TENNCARE shall provide a notice of deficiency and request corrective action. The CONTRACTOR may also be subject to the application of liquidated damages and/or intermediate sanctions specified in Sections 5.20.1 and 5.20.2. If the CONTRACTOR is unable to successfully implement corrective action and demonstrate adherence with timely claims processing requirements within the time approved by TENNCARE, the State may terminate this Agreement in accordance with Section 5.4 of this Agreement.

5.20.4 Failure to Manage Medical Costs

If TENNCARE determines the CONTRACTOR is unable to successfully manage costs for covered services, TENNCARE may terminate this Agreement with ninety (90) calendar days advance notice in accordance with Section 5.4 of this Agreement.

5.20.5 Sanctions by CMS

Payments provided for under this Agreement will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS in accordance with the requirements in 42 CFR 438.730.

5.20.6 Temporary Management

TENNCARE may impose temporary management if it finds that the CONTRACTOR has repeatedly failed to meet substantive requirements in Section 1903(m) or Section 1932 of the Social Security Act.

5.21 MODIFICATION AND AMENDMENT

Renegotiation procedures and criteria for amending this Agreement shall be as follows:

- a. For good cause, only at the end of the contract period; and
- b. For modification(s) during the contract period, if circumstances warrant.

This Agreement may be amended at anytime as provided in this paragraph. This Agreement shall be amended automatically without action by the parties whenever required by changes in state and federal law or regulations. No other modification or change of any provision of the Agreement shall be made or construed to have been made unless such modification is mutually agreed to in writing by the CONTRACTOR and TENNCARE and incorporated as a written amendment to this Agreement prior to the effective date of such modification or change.

5.22 TITLES/HEADINGS

Titles of paragraphs or section headings used herein are for the purpose of facilitating use or reference only and shall not be construed to infer a contractual construction of language.

5.23 OFFER OF GRATUITIES

By signing this Agreement, the CONTRACTOR certifies that no member of or a delegate of Congress, nor any elected or appointed official or employee of the State of Tennessee, the United States General Accounting Office, United States Department of Health and Human Services, CMS, or any other federal agency has or will benefit financially or materially due to influence in obtaining this Agreement. This Agreement may be terminated by TENNCARE if it is determined that gratuities of any kind were offered to or received by any of the aforementioned officials or employees from the CONTRACTOR or the CONTRACTOR's agent or employees.

5.24 LOBBYING

5.24.1 The CONTRACTOR certifies by signing this Agreement, to the best of its knowledge and belief, that federal funds have not been used for lobbying in accordance with 45 CFR Part 93 and 31 USC 1352.

5.24.2 The CONTRACTOR shall disclose any lobbying activities using non-federal funds in accordance with 45 CFR Part 93.

5.25 ATTORNEY'S FEES

In the event that either party deems it necessary to take legal action to enforce any provision of this Agreement, and TENNCARE prevails, the CONTRACTOR agrees to pay all expenses of such action, including attorney's fees and cost of all state litigation as may be set by the court or hearing officer. Legal actions are defined to include administrative proceedings.

5.26 GOVERNING LAW AND VENUE

5.26.1 This Agreement shall be governed by and construed in accordance with the laws of the State of Tennessee. The CONTRACTOR agrees that it will be subject to the exclusive jurisdiction of the courts of the State of Tennessee in actions that may arise under this Agreement.

5.26.2 For purposes of any legal action occurring as a result of or under this Agreement between the CONTRACTOR and TENNCARE, the place of proper venue shall be Davidson County, Tennessee.

5.27 ASSIGNMENT

This Agreement and the monies that may become due hereunder are not assignable by the CONTRACTOR except with the prior written approval of TENNCARE.

5.28 INDEPENDENT CONTRACTOR

It is expressly agreed that the CONTRACTOR and any subcontractors or providers, and agents, officers, and employees of the CONTRACTOR or any subcontractors or providers, in the performance of this Agreement shall act in an independent capacity and not as agents, officers and employees of TENNCARE or the State of Tennessee. It is further expressly agreed that this Agreement shall not be construed as a partnership or joint venture between the CONTRACTOR or any subcontractor or provider and TENNCARE and the State of Tennessee.

5.29 FORCE MAJEURE

TENNCARE shall not be liable for any excess administrative cost to the CONTRACTOR for TENNCARE's failure to perform the duties required by this Agreement if such failure arises out of causes beyond the control and without the result of fault or negligence on the part of TENNCARE. In all cases, the failure to perform must be beyond the control without the fault or negligence of TENNCARE. The CONTRACTOR shall not be liable for performance of the duties and responsibilities of this Agreement when its ability to perform is prevented by causes beyond its control. These acts must occur without the fault or negligence of the CONTRACTOR. Such acts include destruction of the facilities due to hurricanes, fires, war, riots, and other similar acts. However, in the event of damage to its facilities, the CONTRACTOR shall be responsible for ensuring swift correction of the problem so as to enable it to continue its responsibility for the delivery of covered services. The failure of the CONTRACTOR's fiscal intermediary to perform any requirements of this Agreement shall not be considered a 'force majeure'.

5.30 VOLUNTARY BUYOUT PROGRAM

5.30.1 The CONTRACTOR acknowledges and understands that, for a period of two years beginning August 16, 2008, restrictions are imposed on former state employees who received a State of Tennessee Voluntary Buyout Program (VBP) severance payment with regard to contracts with state agencies that participated in the VBP.

5.30.2 The State will not contract with either a former state employee who received a VBP severance payment or an entity in which a former state employee who received a VBP severance payment or the spouse of such an individual holds a controlling financial interest.

- 5.30.3 The State may contract with an entity with which a former state employee who received a VBP severance payment is an employee or an independent contractor. Notwithstanding the foregoing, the CONTRACTOR understands and agrees that there may be unique business circumstances under which a return to work by a former state employee who received a VBP severance payment as an employee or an independent contractor of a State contractor would not be appropriate, and in such cases the State may refuse CONTRACTOR personnel. Inasmuch, it shall be the responsibility of the State to review CONTRACTOR personnel to identify any such issues.
- 5.30.4 With reference to either Section 5.30.2 or 5.30.3 above, the CONTRACTOR may submit a written request for a waiver of the VBP restrictions regarding a former state employee and a contract with a state agency that participated in the VBP. Any such request must be submitted to the State in the form of the *VBP Contracting Restriction Waiver Request* format available from the State and the Internet at: www.state.tn.us/finance/rds/ocr/waiver.html. The determination on such a request shall be at the sole discretion of the head of the state agency that is a Party to this Agreement, the Commissioner of Finance and Administration, and the Commissioner of Human Resources.

5.31 INDEMNIFICATION

- 5.31.1 The CONTRACTOR shall indemnify and hold harmless the State as well as its officers, agents, and employees (hereinafter the “Indemnified Parties”) from all claims, losses or suits incurred by or brought against the Indemnified Parties as a result of the failure of the CONTRACTOR to comply with the terms of this Agreement. The State shall give the CONTRACTOR written notice of each such claim or suit and full right and opportunity to conduct CONTRACTOR’s own defense thereof, together with full information and all reasonable cooperation; but the State does not hereby accord to the CONTRACTOR, through its attorneys, any right(s) to represent the State of Tennessee in any legal matter, such right being governed by TCA 8-6-106.
- 5.31.2 The CONTRACTOR shall indemnify and hold harmless the Indemnified Parties as well as their officers, agents, and employees from all claims or suits which may be brought against the Indemnified Parties for infringement of any laws regarding patents or copyrights which may arise from the CONTRACTOR’s or Indemnified Parties performance under this Agreement. In any such action, brought against the Indemnified Parties, the CONTRACTOR shall satisfy and indemnify the Indemnified Parties for the amount of any final judgment for infringement. The State shall give the CONTRACTOR written notice of each such claim or suit and full right and opportunity to conduct the CONTRACTOR’s own defense thereof, together with full information and all reasonable cooperation; but the State does not hereby accord to the CONTRACTOR, through its attorneys, any right(s) to represent the State of Tennessee in any legal matter, such right being governed by TCA 8-6-106.
- 5.31.3 While the State will not provide a contractual indemnification to the CONTRACTOR, such shall not act as a waiver or limitation of any liability for which the State may otherwise be legally responsible to the CONTRACTOR. The CONTRACTOR retains all of its rights to seek legal remedies against the State for losses the CONTRACTOR may incur in connection with the furnishing of services under this Agreement or for the failure of the State to meet its obligations under the Agreement.

5.32 NON-DISCRIMINATION

- 5.32.1 No person on the grounds of handicap, and/or disability, age, race, color, religion, beliefs, sex, or national origin, shall be excluded from participation in, except as specified in Section 2.3.5 of this

Agreement, or be denied benefits of, or be otherwise subjected to discrimination in the performance of this Agreement or in the employment practices of the CONTRACTOR.

5.32.2 The CONTRACTOR shall upon request show proof of such non-discrimination.

5.32.3 The CONTRACTOR shall post notices of non-discrimination in conspicuous places, available to all employees and applicants.

5.33 CONFIDENTIALITY OF INFORMATION

5.33.1 The CONTRACTOR shall comply with all state and federal law regarding information security and confidentiality of information. In the event of a conflict among these requirements, the CONTRACTOR shall comply with the most restrictive requirement.

5.33.2 All material and information, regardless of form, medium or method of communication, provided to the CONTRACTOR by the State or acquired by the CONTRACTOR pursuant to this Agreement shall be regarded as confidential information in accordance with the provisions of state and federal law and ethical standards and shall not be disclosed, and all necessary steps shall be taken by the CONTRACTOR to safeguard the confidentiality of such material or information in conformance with state and federal law and ethical standards.

5.33.3 The CONTRACTOR shall ensure that all material and information, in particular information relating to members or potential members, which is provided to or obtained by or through the CONTRACTOR's performance under this Agreement, whether verbal, written, tape, or otherwise, shall be treated as confidential information to the extent confidential treatment is provided under state and federal laws. The CONTRACTOR shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under this Agreement and in compliance with federal and state law.

5.33.4 All information as to personal facts and circumstances concerning members or potential members obtained by the CONTRACTOR shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of TENNCARE or the member/potential member, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning members/potential members shall be limited to purposes directly connected with the administration of this Agreement and shall be in compliance with federal and state law.

5.34 PROHIBITION OF ILLEGAL IMMIGRANTS

5.34.1 The requirements of Public Acts of 2006, Chapter Number 878, of the state of Tennessee, addressing the use of illegal immigrants in the performance of any contract to supply goods or services to the state of Tennessee, shall be a material provision of this Agreement, a breach of which shall be grounds for monetary and other penalties, up to and including termination of this Agreement.

- 5.34.2 The CONTRACTOR hereby attests, certifies, warrants, and assures that the CONTRACTOR shall not knowingly utilize the services of an illegal immigrant in the performance of this Agreement and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Agreement. The CONTRACTOR shall reaffirm this attestation, in writing, by submitting to the State a completed and signed copy of the document as Attachment X, hereto, semi-annually during the period of this Agreement. Such attestations shall be maintained by the CONTRACTOR and made available to state officials upon request.
- 5.34.3 Prior to the use of any subcontractor in the performance of this Agreement, and semi-annually thereafter, during the period of this Agreement, the CONTRACTOR shall obtain and retain a current, written attestation that the subcontractor shall not knowingly utilize the services of an illegal immigrant to perform work relative to this Agreement and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant to perform work relative to this Agreement. Attestations obtained from such subcontractors shall be maintained by the CONTRACTOR and made available to state officials upon request.
- 5.34.4 The CONTRACTOR shall maintain records for all personnel used in the performance of this Agreement. Said records shall be subject to review and random inspection at any reasonable time upon reasonable notice by the State.
- 5.34.5 The CONTRACTOR understands and agrees that failure to comply with this Section will be subject to the sanctions of Public Chapter 878 of 2006 for acts or omissions occurring after its effective date. This law requires the Commissioner of Finance and Administration to prohibit a contractor from contracting with, or submitting an offer, proposal, or bid to contract with the State of Tennessee to supply goods or services for a period of one year after a contractor is discovered to have knowingly used the services of illegal immigrants during the performance of this Agreement.
- 5.34.6 For purposes of this Agreement, "illegal immigrant" shall be defined as any person who is not either a United States citizen, a Lawful Permanent Resident, or a person whose physical presence in the United States is authorized or allowed by the federal Department of Homeland Security and who, under federal immigration laws and/or regulations, is authorized to be employed in the U.S. or is otherwise authorized to provide services under the Agreement.

5.35 TENNESSEE CONSOLIDATED RETIREMENT SYSTEM

The CONTRACTOR acknowledges and understands that, subject to statutory exceptions contained in TCA 8-36-801, *et seq.*, the law governing the Tennessee Consolidated Retirement System (TCRS), provides that if a retired member of TCRS, or of any superseded system administered by TCRS, or of any local retirement fund established pursuant to TCA, Title 8, Chapter 35, Part 3 accepts state employment, the member's retirement allowance is suspended during the period of the employment. Accordingly and notwithstanding any provision of this Agreement to the contrary, the CONTRACTOR agrees that if it is later determined that the true nature of the working relationship between the CONTRACTOR and the State under this Agreement is that of "employee/employer" and not that of an independent contractor, the CONTRACTOR may be required to repay to TCRS the amount of retirement benefits the CONTRACTOR received from TCRS during the period of this Agreement.

5.36 ACTIONS TAKEN BY THE TENNESSEE DEPARTMENT OF COMMERCE AND INSURANCE

The parties acknowledge that the CONTRACTOR is licensed to operate as a health maintenance organization in the State of Tennessee, and is subject to regulation and supervision by TDCI. The parties acknowledge that no action by TDCI to regulate the activities of the CONTRACTOR as a health maintenance organization, including, but not limited to, examination, entry of a remedial order pursuant to TCA 56-9-101, *et seq.*, and regulations promulgated thereunder, supervision, or institution of delinquency proceedings under state law, shall constitute a breach of this Agreement by TENNCARE.

5.37 FEDERAL ECONOMIC STIMULUS FUNDING

This Agreement requires the CONTRACTOR to provide products and/or services that are funded in whole or in part under the American Recovery and Reinvestment Act of 2009, Public Law 111-5 (Recovery Act). The CONTRACTOR is responsible for ensuring that all applicable requirements of the Recovery Act are met and that the CONTRACTOR provides information to the State as required by, but not limited to, the following:

5.37.1 The Recovery Act, including but not limited to the following sections of that Act:

5.37.1.1 Section 1606 – Wage Rate Requirements.

5.37.1.2 Section 1512 – Reporting and Registration Requirements.

5.37.1.3 Sections 902, 1514, and 1515 – General Accounting Office/Inspector General Access.

5.37.1.4 Section 1553 – Whistleblower Protections.

5.37.1.5 Section 1605 – Buy American Requirements for Construction Material.

5.37.2 Executive Office of the President, Office of Management and Budget (OMB) Guidelines as posted at http://www.whitehouse.gov/omb/recovery_default/, as well as OMB Circulars, including but not limited to A-102 and A-133 as posted at http://www.whitehouse.gov/omb/financial_offm_circulars/.

5.37.3 Federal Grant Award Documents.

5.37.4 Office of Tennessee Recovery Act Management Directives.

5.38 EFFECT OF THE FEDERAL WAIVER ON THIS AGREEMENT

The provisions of this Agreement are subject to the receipt of and continuation of a federal waiver granted to the State of Tennessee by the Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. Should the waiver cease to be effective, the State shall have the right to immediately terminate this Agreement. Said termination shall not be a breach of this Agreement by TENNCARE and TENNCARE shall not be responsible to the CONTRACTOR or any other party for any costs, expenses, or damages occasioned by said termination.

5.39 TENNCARE FINANCIAL RESPONSIBILITY

Notwithstanding any provision which may be contained herein to the contrary, TENNCARE shall be responsible solely to the CONTRACTOR for the amount described herein and in no event shall TENNCARE be responsible, either directly or indirectly, to any subcontractor or any other party who may provide the services described herein.

46. Section 6 shall be deleted in its entirety including all references thereto.

47. Attachment I shall be amended by deleting Attachment I in its entirety and replacing it with the following and renumbering all references thereto:

**ATTACHMENT I
BEHAVIORAL HEALTH SPECIALIZED SERVICE DESCRIPTIONS**

The CONTRACTOR shall provide medically necessary mental health case management and psychiatric rehabilitation services according to the requirements herein.

SERVICE	Mental Health Case Management
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DEFINITION

Mental health case management is a supportive service provided to enhance treatment effectiveness and outcomes with the goal of maximizing resilience and recovery options and natural supports for the individual. Mental health case management is consumer-centered, consumer focused and strength-based, with services provided in a timely, appropriate, effective, efficient and coordinated fashion. It consists of activities performed by a team or a single mental health case manager to support clinical services. Mental health case managers assist in ensuring the individual/family access to services.

Mental health case management requires that the mental health case manager and the individual and/or family have a strong productive relationship which includes viewing the individual/family as a responsible partner in identifying and obtaining the necessary services and resources. Services rendered to children and youth shall be consumer-centered and family-focused with case managers working with multiple systems (e.g. education, child welfare, juvenile justice). Mental health case management is provided in community settings, which are accessible and comfortable to the individual/family. The service should be rendered in a culturally competent manner and be outcome driven. Mental health case management shall be available 24 hours a day, 7 days a week. The service is not time limited and provides the individual/family the opportunity to improve their quality of life.

The CONTRACTOR shall ensure mental health case management is rendered in accordance with all of the service components and guidelines herein.

SERVICE DELIVERY

The CONTRACTOR shall:

- Determine caseload size based on an average number of individuals per case manager, with the expectation being that case managers will have mixed caseloads of clients and flexibility between Levels 1 and 2 (Levels 1 and 2 are defined below); and
- Ensure that caseload sizes and minimum contacts are met as follows:

Case Management Type	Maximum Caseload Size	Minimum Face-to-Face Contacts
Level 1 (Non-Team Approach)*	25 individuals:1 case manager	One (1) contact per week
Level 1 (Team Approaches):		
Adult CTT	20 individuals:1 team 20 individuals:1 case manager	One (1) contact per week
Children & Youth (C&Y) CTT	15 individuals:1 team 15 individuals:1 case manager	One (1) contact per week
CCFT	15 individuals:1 team 15 individuals:1 case manager	One (1) contact per week
ACT	100 individuals:1 team 15 individuals:1 case manager	One (1) contact per week
PACT	100 individuals:1 team 15 individuals:1 case manager	One (1) contact per week
Level 2*	35 individuals:1 case manager	Two (2) contacts per month

*For case managers having a combination of Level 1 & Level 2 (non-team) individuals, the maximum caseload size shall be no more than 30 individuals:1 case manager.

The CONTRACTOR shall ensure that the following requirements are met:

- 1) All mental health case managers shall have, at a minimum, a bachelor's degree;
- 2) Supervisors shall maintain no greater than a 1:30 supervisory ratio with mental health case managers;
- 3) Mental health case managers who are assigned to both a parent(s) and child in the same family, should have skills and experience needed for both ages; mental health case managers who are assigned to individuals with co-occurring disorders (mental illness and substance abuse disorders) should have the skills and experience to meet the needs of these individuals;
- 4) Eighty percent (80%) of all mental health case management services should take place outside the case manager's office;
- 5) The children and youth (C&Y) (under age eighteen (18)) mental health case management model shall provide a transition from C&Y services into adult services, including adult mental health case management services. The decision to serve an 18-year old youth via the C&Y case management system versus the adult system shall be a clinical one made by a provider. Transition from children's services, including mental health case management, shall be incorporated into the child's treatment plan; and
- 6) All mental health case management services shall be documented in a treatment plan. Mental health case management activities are correlated to expected outcomes and outcome achievement and shall be monitored, with progress being noted periodically in a written record.

Level 1

Level 1 mental health case management is the most intense level of service. It provides frequent and comprehensive support to individuals with a focus on recovery and resilience. The CONTRACTOR shall ensure the provision of level 1 mental health case management to the most severely disabled adults and emotionally disturbed children and youth, including individuals who are at high risk of future hospitalization or placement out of the home and require both community support and treatment interventions. Level 1 mental health case management can be rendered through a team approach or by

individual mental health case managers. Team approaches may include such models as ACT, CTT, CCFT and PACT, as described below:

Assertive Community Treatment (ACT)

ACT is a way of delivering comprehensive and effective services to adults diagnosed with severe mental illness and who have needs that have not been well met by traditional approaches to delivering services. The principles of ACT include:

- 1) Services targeted to a specific group of individuals with severe mental illness;
- 2) Treatment, support and rehabilitation services provided directly by the ACT team;
- 3) Sharing of responsibility between team members and individuals served by the team;
- 4) Small staff (all team staff including case managers) to individual ratios (approx. 1 to 10);
- 5) Comprehensive and flexible range of treatment and services;
- 6) Interventions occurring in community settings rather than in hospitals or clinic settings;
- 7) No arbitrary time limit on receiving services;
- 8) Individualized treatment, support and rehabilitation services;
- 9) Twenty-four (24) hour a day availability of services; and
- 10) Engagement of individuals in treatment and monitoring.

Continuous Treatment Team (CTT)

CTT is a coordinated team of staff (to include physicians, nurses, case managers, and other therapists as needed) who provide a range of intensive, integrated mental health case management, treatment, and rehabilitation services to adults and children and youth. The intent is to provide intensive treatment to families of children and youth with acute psychiatric problems in an effort to prevent removal from the home to a more restrictive level of care. An array of services are delivered in the home or in natural settings in the community, and are provided through a strong partnership with the family and other community support systems. The program provides services including crisis intervention and stabilization, counseling, skills building, therapeutic intervention, advocacy, educational services, medication management as indicated, school based counseling and consultation with teachers, and other specialized services deemed necessary and appropriate.

Comprehensive Child and Family Treatment (CCFT)

CCFT services are high intensity, time-limited services designed for children and youth to provide stabilization and deter the “imminent” risk of State custody for the individual. There is usually family instability and high-risk behaviors exhibited by the child/adolescent. CCFT services are concentrated on child, family, and parental/guardian behaviors and interaction. CCFT services are more treatment oriented and situation specific with a focus on short-term stabilization goals. The primary goal of CCFT is to reach an appropriate point of stabilization so the individual can be transitioned to a less intense outpatient service.

Program of Assertive and Community Treatment (PACT)

PACT is a service delivery model for providing comprehensive community-based treatment to adults with severe and persistent mental illness. It involves the use of a multi-disciplinary team of mental health staff organized as an accountable, mobile mental health agency or group of providers who function as a team interchangeably to provide the treatment, rehabilitation and support services persons with severe and/or persistent mental illnesses need to live successfully in the community.

Level 2

Level 2 mental health case management is a less intensive level of service than Level 1 and is focused on resilience and recovery. The CONTRACTOR shall ensure that level 2 mental health case management is provided to individuals whose symptoms are at least partially stabilized or reduced in order to allow treatment and rehabilitation efforts.

SERVICE COMPONENTS

The CONTRACTOR shall ensure that mental health case management incorporates the following service components:

Crisis Facilitation

Crisis facilitation is provided in situations requiring immediate attention/resolution for a specific individual or other person(s) in relation to a specific individual. It is the process of accessing and coordinating services for an individual in a crisis situation to ensure the necessary services are rendered during and following the crisis episode. Most crisis facilitation activities would involve face-to-face contact with the individual.

Assessment of Daily Functioning

Assessment of daily functioning involves the on-going monitoring of how an individual is coping with life on a day to day basis for the purposes of determining necessary services to maintain community placement and improve level of functioning. Most assessments of daily functioning are achieved by face-to-face contact with the individual in his or her natural environment.

Assessment/Referral/Coordination

Assessment/referral/coordination involves assessing the needs of the individual for the purposes of referral and coordination of services that will improve functioning and/or maintain stability in the individual's natural environment.

Mental Health Liaison

Mental health liaison services are offered to persons who are not yet assigned to mental health case management. It is a short-term service for the purposes of service referral and continuing care until other mental health services are initiated.

SERVICE	Psychiatric Rehabilitation
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DEFINITION

Psychiatric rehabilitation is an array of consumer-centered recovery services designed to support the individual in the attainment or maintenance of his or her optimal level of functioning. These services are designed to capitalize on personal strengths, develop coping skills and strategies to deal with deficits and develop a supportive environment in which to function as independent as possible on the individual's recovery journey.

Services included under psychiatric rehabilitation are as follows.

SERVICE COMPONENTS

Psychosocial Rehabilitation

Psychosocial rehabilitation services utilize a comprehensive approach (mind, body, and spirit) to work with the whole person for the purposes of improving an individuals' functioning, promoting management of illness(s), and facilitating recovery. The goal of psychosocial rehabilitation is to support individuals as active and productive members of their communities. Individuals, in partnership with staff, form goals for skills development in the areas of vocational, educational, and interpersonal growth (e.g. household management, development of social support networks) that serve to maximize opportunities for successful community integration. Individuals proceed toward goal attainment at their own pace and may continue in the program at varying levels intensity for an indefinite period of time.

Supported Employment

Supported employment consists of a range of services to assist individuals to choose, prepare for, obtain, and maintain gainful employment that is based on individuals' preferences, strengths, and experiences. This service also includes a variety of support services to the individual, including side-by-side support on the job. These services may be integrated into a psychosocial rehabilitation center.

Peer Support

Peer support services allow individuals to direct their own recovery and advocacy process and are provided by persons who are or have been consumers of the behavioral health system and their family members and are Certified Peer Support Specialists. These services include providing assistance with more effectively utilizing the service delivery system (e.g. assistance in developing plans of care, accessing services and supports, partnering with professionals) or understanding and coping with the stressors of the person's illness through support groups, coaching, role modeling, and mentoring. Activities which promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills are rendered so individuals can educate and support each other in the acquisition of skills needed to manage their illnesses and access resources within their communities. Services are often provided during the evening and weekend hours.

Illness Management & Recovery

Illness management and recovery services refers to a series of weekly sessions with trained mental health practitioners for the purpose of assisting individuals in developing personal strategies for coping with mental illness and promoting recovery.

Supported Housing

Supported housing services refers to services rendered at facilities that are staffed twenty-four (24) hours per day, seven (7) days a week with associated mental health staff supports for individuals who require

treatment services and supports in a highly structured setting. These mental health services are for persons with serious and/or persistent mental illnesses (SPMI) and are intended to prepare individuals for more independent living in the community while providing an environment that allows individuals to live in community settings. Given this goal, every effort should be made to place individuals in facilities near their families and other support systems and original areas of residence. Supported housing services are mental health services and do not include the payment of room and board.

48. Attachment II shall be amended by deleting Attachment II in its entirety and replacing it with the following and renumbering all references thereto:

**ATTACHMENT II
COST SHARING SCHEDULES**

**Non-Pharmacy Copayment Schedule Prior to January 1, 2010
(unless otherwise directed by TENNCARE)**

Poverty Level	Copayment Amounts
0% - 99%	\$0.00
100% - 199%	\$25.00, Hospital Emergency Room (waived if admitted) \$5.00, Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care \$15.00, Physician Specialists (including Psychiatrists) \$100.00, Inpatient Hospital Admission
200% and above	\$50.00, Hospital Emergency Room (waived if admitted) \$10.00, Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care \$25.00, Physician Specialists (including Psychiatrists) \$200.00, Inpatient Hospital Admission

**Non-Pharmacy Copayment Schedule Effective January 1, 2010
(unless otherwise directed by TENNCARE)**

Poverty Level	Copayment Amounts
0%-99%	\$0.00
100% - 199%	\$10.00, Hospital Emergency Room (waived if admitted) \$5.00, Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care \$5.00, Physician Specialists (including Psychiatrists) \$5.00, Inpatient Hospital Admission (waived if readmitted within 48 hours for the same episode)
200% and above	\$50.00, Hospital Emergency Room (waived if admitted) \$15.00, Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care \$20.00, Physician Specialists (including Psychiatrists) \$100.00, Inpatient Hospital Admission (waived if readmitted within 48 hours for the same episode)

The CONTRACTOR is specifically prohibited from waiving or discouraging TENNCARE enrollees from paying the amounts described in this attachment.

- 49. Attachment III shall be amended by deleting Attachment III in its entirety and replacing it with the following and renumbering all references thereto:**

**ATTACHMENT III
GENERAL ACCESS STANDARDS**

In general, contractors shall provide available, accessible, and adequate numbers of institutional facilities, service locations, service sites, professional, allied, and paramedical personnel for the provision of covered services, including all emergency services, on a 24-hour-a-day, 7-day-a-week basis. At a minimum, this shall include:

- Primary Care Physician or Extender:
 - (a) Distance/Time Rural: 30 miles or 30 minutes
 - (b) Distance/Time Urban: 20 miles or 30 minutes
 - (c) Patient Load: 2,500 or less for physician; one-half this for a physician extender.
 - (d) Appointment/Waiting Times: Usual and customary practice (see definition below), not to exceed 3 weeks from date of a patient's request for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.
 - (e) Documentation/Tracking requirements:
 - + Documentation - Plans must have a system in place to document appointment scheduling times.
 - + Tracking - Plans must have a system in place to document the exchange of member information if a provider, other than the primary care provider (i.e., school-based clinic or health department clinic), provides health care.
- Specialty Care and Emergency Care: Referral appointments to specialists (e.g., specialty physician services, hospice care, home health care, substance abuse treatment, rehabilitation services, etc.) shall not exceed 30 days for routine care or 48 hours for urgent care. All emergency care is immediate, at the nearest facility available, regardless of contract. Waiting times shall not exceed 45 minutes.
- Hospitals
 - (a) Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where access time may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented to the State on the basis of community standards.
- General Optometry Services:
 - (a) Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where community standards and documentation shall apply.

- (b) Appointment/Waiting Times: Usual and customary not to exceed 3 weeks for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.
- Lab and X-Ray Services:
 - (a) Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where community access standards and documentation will apply.
 - (b) Appointment/Waiting Times: Usual and customary not to exceed 3 weeks for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.
- All other services not specified here shall meet the usual and customary standards for the community.

50. Attachment IV shall be amended by deleting Attachment IV in its entirety and replacing it with the following and renumbering all references thereto:

**ATTACHMENT IV
SPECIALTY NETWORK STANDARDS**

The CONTRACTOR shall adhere to the following specialty network requirements to ensure access and availability to specialists for all members (adults and children) who are not dually eligible for Medicare and TennCare (non-dual members). For the purpose of assessing specialty provider network adequacy, TENNCARE will evaluate the CONTRACTOR's provider network relative to the requirements described below. A provider is considered a "specialist" if he/she has a provider agreement with the CONTRACTOR to provide specialty services to members.

Access to Specialty Care

The CONTRACTOR shall ensure access to specialty providers (specialists) for the provision of covered services. At a minimum, this means that:

- (1) The CONTRACTOR shall have provider agreements with providers practicing the following specialties: Allergy, Cardiology, Dermatology, Endocrinology, Otolaryngology, Gastroenterology, General Surgery, Nephrology, Neurology, Neurosurgery, Oncology/Hematology, Ophthalmology, Orthopedics, Psychiatry (adult), Psychiatry (child and adolescent) and Urology; and
- (2) The following access standards are met:
 - Travel distance does not exceed 60 miles for at least 75% of non-dual members and
 - Travel distance does not exceed 90 miles for ALL non-dual members

Availability of Specialty Care

The CONTRACTOR shall provide adequate numbers of specialists for the provision of covered services to ensure adequate provider availability for its non-dual members. To account for variances in MCO enrollment size, the guidelines described in this Attachment have been established for determining the number of specialists with whom the CONTRACTOR must have a provider agreement. These are aggregate guidelines and are not age specific. To determine these guidelines the number of providers within each Grand Region was compared to the size of the population in each Grand Region. The

CONTRACTOR shall have a sufficient number of provider agreements with each type of specialist in each Grand Region served to ensure that the number of non-dual members per provider does not exceed the following:

Maximum Number of Non-Dual Members per Provider by Specialty

Specialty	Number of Non-Dual Members
Allergy & Immunology	100,000
Cardiology	20,000
Dermatology	40,000
Endocrinology	25,000
Gastroenterology	30,000
General Surgery	15,000
Nephrology	50,000
Neurology	35,000
Neurosurgery	45,000
Oncology/Hematology	80,000
Ophthalmology	20,000
Orthopedic Surgery	15,000
Otolaryngology	30,000
Psychiatry (adult)	25,000
Psychiatry (child & adolescent)	150,000
Urology	30,000

51. **Attachment V shall be amended by deleting Attachment V in its entirety and replacing it with the following and renumbering all references thereto:**

**ATTACHMENT V
ACCESS & AVAILABILITY FOR BEHAVIORAL HEALTH SERVICES**

The CONTRACTOR shall adhere to the following behavioral health network requirements to ensure access and availability to behavioral health services for all members (adults and children). For the purpose of assessing behavioral health provider network adequacy, TENNCARE will evaluate the CONTRACTOR’s provider network relative to the requirements described below. Providers serving adults will be evaluated separately from those serving children.

Access to Behavioral Health Services

The CONTRACTOR shall ensure access to behavioral health providers for the provision of covered services. At a minimum, this means that:

The CONTRACTOR shall have provider agreements with providers of the services listed in the table below and meet the geographic **and** time for admission/appointment requirements.

Service Type	Geographic Access Requirement	Maximum Time for Admission/ Appointment
Psychiatric Inpatient Hospital Services	Travel distance does not exceed 60 miles for at least 75% of members and does not exceed 90 miles for at least 90% of members	4 hours (emergency involuntary)/24 hours (involuntary)/24 hours (voluntary)
24 Hour Psychiatric Residential Treatment	Travel distance does not exceed 75 miles for at least 75% of ADULT members and does not exceed 150 miles for at least 90% of ADULT members ----- Travel distance does not exceed 60 miles for at least 75% of CHILD members and does not exceed 90 miles for at least 90% of CHILD members	Within 30 calendar days
Outpatient Non-MD Services	Travel distance does not exceed 30 miles for ALL members	Within 10 business days; if urgent, within 48 hours
Intensive Outpatient (may include Day Treatment (adult), Intensive Day Treatment (Children & Adolescent) or Partial Hospitalization)	Travel distance does not exceed 60 miles for at least 75% of members and does not exceed 90 miles for at least 90% of members	Within 10 business days; if urgent, within 48 hours
Inpatient Facility Services (Substance Abuse)	Travel distance does not exceed 60 miles for at least 75% of members and does not exceed 90 miles for at least 90% of members	Within 2 calendar days; for detoxification - within 4 hours in an emergency and 24 hours for non-emergency
24 Hour Residential Treatment Services (Substance Abuse)	Travel distance does not exceed 75 miles for at least 75% of members and does not exceed 120 miles for at least 90% of members	Within 10 business days
Outpatient Treatment Services (Substance Abuse)	Travel distance does not exceed 30 miles for ALL members	Within 10 business days; for detoxification – within 24 hours
Mental Health Case Management	Not subject to geographic access standards	Within 7 calendar days
Psychosocial Rehabilitation (may include Supported Employment, Illness Management & Recovery, or Peer Support)	Not subject to geographic access standards	Within 10 business days
Supported Housing	Travel distance does not exceed 60 miles for at least 75% of ADULT members and does not exceed 90 miles for at least 90% of ADULT members	Within 30 calendar days

Service Type	Geographic Access Requirement	Maximum Time for Admission/ Appointment
Crisis Services (Mobile)	Not subject to geographic access standards	Face-to-face contact within 1 hour for emergency situations and 4 hours for urgent situations

When the above standards are not met, an acceptable Corrective Action Plan will be requested which details the CONTRACTOR’s intended course of action to resolve any deficiency (ies) identified. The Bureau of TennCare will evaluate Corrective Action Plans and, at its sole discretion, determine network adequacy considering any alternate measures and documentation of unique market conditions.

At a minimum, providers for the following service types shall be reported on the Provider Enrollment File:

Service Type	Service Code(s) for use in position 330-331 of the Provider Enrollment File
Psychiatric Inpatient Hospital Services	Adult - 11, 79, 85 Child – A1 or H9
24 Hour Psychiatric Residential Treatment	Adult - 13, 81, 82 Child – A9, H1, or H2
Outpatient MD Services (Psychiatry)	Adult – 19 Child – B5
Outpatient Non-MD Services	Adult – 20 Child – B6
Intensive Outpatient/ Partial Hospitalization	Adult – 21, 23, 62 Child - B7, C2, C3
Inpatient Facility Services (Substance Abuse)	Adult – 15, 17 Child – A3, A5
24 Hour Residential Treatment Services (Substance Abuse)	Adult - 56 Child - F6
Outpatient Treatment Services (Substance Abuse)	Adult – 27 or 28 Child – D3 or D4
Mental Health Case Management	Adult - 31, 66, or 83 Child – C7, D7, G2, G6, or K1
Psychiatric Rehabilitation Services:	
Psychosocial Rehabilitation	42
Supported Employment	44
Peer Support	88
Illness Management & Recovery	91
Supported Housing	32 and 33
Crisis Services (Mobile)	Adult - 37, 38, 39 Child - D8, D9, E1

Crisis Respite	Adult – 40 Child – E2
Crisis Stabilization	Adult – 41

52. Attachment VI shall be amended by deleting Attachment VI in its entirety and replacing it with the following and renumbering all references thereto:

**ATTACHMENT VI
TENNESSEE BUREAU OF INVESTIGATION
MEDICAID FRAUD CONTROL UNIT
FRAUD ALLEGATION REFERRAL FORM**

DATE: _____

TO (circle recipient): **SAC Bob Schlafly** [fax (615) 744-4659]
ASAC Stephen Phelps [fax (731) 668-9769]
ASAC Norman Tidwell [fax (615) 744-4659]

FROM: _____ (TennCare Contractor)

Contact Person: _____
Telephone: _____
E-Mail: _____

SUBJECT NAME: _____ **d/b/a** _____
SUBJECT ADDRESS: _____

PROVIDER NUMBER(S): _____

SUMMARY OF COMPLAINT:

ADDITIONAL SUBJECT INFORMATION:

REPORT TENNCARE RECIPIENT FRAUD OR ABUSE

Date:

Please complete as much information as possible.

Name of Recipient/Person you are Reporting recipient name or name of individual suspected of fraud

Other Names Used (If known) alias

Social Security Number (If known)

Date of Birth

Children's Name (if applicable)

SSN, if known

DOB, if known

SSN, if known

DOB, if known

Spouse's Name (if applicable)

Street Address

physical address

Apartment #

City, State, Zip

city state zip

Other Addresses Used

Home Phone Number

area code

Work Phone Number (Please include)

area code

Employer's Name

Employer's Address

Employer's Phone #

area code

What is your complaint? (In your own words, explain the problem)describe suspected fraudulent behavior

Have you notified the Managed Care Contractor of this problem? Yes No

Who did you notify? (Please provide name and phone number, if known)name phone number dept/ business

Have you notified anyone else? No Yes name phone dept/ business

Requesting Drug Profile Yes No **Have already received drug profile** Yes No

If you are already working with a PID staff person, who?

***Please attach any records of proof that may be needed to complete the initial review.**

OIG/CID Investigator: your name

Phone number

STATE OF TENNESSEE
OFFICE OF TENNCARE INSPECTOR GENERAL
PO BOX 282368
NASHVILLE, TENNESSEE 37228

FRAUD TOLL FREE HOTLINE 1-800-433-3982 •FAX (615) 256-3852

E-Mail Address: www.tennessee.gov/tenncare (follow the prompts that read "Report Fraud Now")

53. Attachment VII shall be amended by deleting Attachment VII in its entirety and replacing it with the following and renumbering all references thereto:

**ATTACHMENT VII
PERFORMANCE STANDARDS**

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
1	Timely Claims Processing	Report from TDCI	<p>90% of clean electronic claims for nursing facility services and HCBS excluding PERS, assistive technology, minor home modifications, and pest control are processed and paid within fourteen (14) calendar days of receipt</p> <p>99.5% of clean electronic claims for nursing facility services and HCBS other than PERS, assistive technology, minor home modifications, and pest control shall be processed and paid within twenty-one (21) calendar days of receipt</p> <p>90% of all other claims (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) calendar days of the receipt of claim</p> <p>99.5% of all other claims are processed within sixty (60) calendar days</p>	<p>Percentage of clean electronic claims paid within 14 calendar days of receipt of claim, for each month</p> <p>Percentage of clean electronic claims processed within 21 calendar days of receipt of claim, determined for month</p> <p>Percentage of claims paid within 30 calendar days of receipt of claim, for each month</p> <p>Percentage of claims processed within 60 calendar days of receipt of claim, for each month</p>	Monthly	\$10,000 for each month determined not to be in compliance
2	Claims Payment Accuracy	Self-reported results based on an internal audit conducted on a statistically valid random sample will be validated by TDCI	97% of claims paid accurately upon initial submission	Percentage of total claims paid accurately for each month and by provider type (NF, HCBS, and other)	Monthly	\$5,000 for each full percentage point accuracy is below 97% for each month for each applicable provider type (NF, HCBS, and other)

Amendment Number 22 (cont.)

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
3	Telephone Response Time/Call Answer Timeliness -Member Services Line	Member Services and Provider Services Phone Line Report	85% of all calls to each line are answered by a live voice within thirty (30) seconds or the prevailing benchmark established by NCQA	The number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the phone line (during hours of operation) during the measurement period	Quarterly	\$25,000 for each full percentage point below 85% per month
4	Telephone Response Time/Call Answer Timeliness -Provider Services Line	Member Services and Provider Services Phone Line Report	85% of all calls to each line are answered by a live voice within thirty (30) seconds or the prevailing benchmark established by NCQA	The number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the phone line (during hours of operation) during the measurement period	Quarterly	\$25,000 for each full percentage point below 85% per month
5	Telephone Response Time/Call Answer Timeliness - Utilization Management Line	Member Services and UM Phone Line Report	85% of all calls to each line are answered by a live voice within thirty (30) seconds or the prevailing benchmark established by NCQA	The number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the phone line (during hours of operation) during the measurement period	Quarterly	\$25,000 for each full percentage point below 85% per month
6	Telephone Response Time/Call Answer Timeliness – Nurse Triage/Nurse Advice Line	Nurse Triage/Nurse Advice Line Report	85% of all calls to each line are answered by a live voice within thirty (30) seconds or the prevailing benchmark established by NCQA	The number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the phone line (during hours of operation) during the measurement period	Quarterly	\$25,000 for each full percentage point below 85% per month
7	Telephone Call Abandonment Rate (unanswered calls) – Member Services Line	Member Services and Provider Services Phone Line Report	Less than 5% of telephone calls are abandoned	The number of calls abandoned by the caller or the system before being answered by a live voice divided by the number of calls received by the phone line (during open hours of operation) during the measurement period	Quarterly	\$25,000 for each full percentage point above 5% per month

Amendment Number 22 (cont.)

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
8	Telephone Call Abandonment Rate (unanswered calls) – Provider Services Line	Member Services and Provider Services Phone Line Report	Less than 5% of telephone calls are abandoned	The number of calls abandoned by the caller or the system before being answered by a live voice divided by the number of calls received by the phone line (during open hours of operation) during the measurement period	Quarterly	\$25,000 for each full percentage point above 5% per month
9	Telephone Call Abandonment Rate (unanswered calls) – UM Line	Member Services and UM Phone Line Report	Less than 5% of telephone calls are abandoned	The number of calls abandoned by the caller or the system before being answered by a live voice divided by the number of calls received by the phone line (during open hours of operation) during the measurement period	Quarterly	\$25,000 for each full percentage point above 5% per month
10	Telephone Call Abandonment Rate (unanswered calls) – Nurse Triage/Nurse Advice Line	Nurse Triage/Nurse Advice Line Report	Less than 5% of telephone calls are abandoned	The number of calls abandoned by the caller or the system before being answered by a live voice divided by the number of calls received by the phone line (during open hours of operation) during the measurement period	Quarterly	\$25,000 for each full percentage point above 5% per month

Amendment Number 22 (cont.)

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
11	Provider Network Documentation	Provider Enrollment File and provider agreement signature pages	100% of providers on the Provider Enrollment File have a signed provider agreement with the CONTRACTOR		Upon TENNCARE request	\$1,000 for each provider for which the CONTRACTOR cannot provide a signature page from the provider agreement between the provider and the CONTRACTOR

Amendment Number 22 (cont.)

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
12	Specialist Provider Network	Provider Enrollment File	<p><u>1. Physician Specialists:</u> Executed specialty physician contracts in all areas required by this Agreement for the following specialists: allergy; cardiology; dermatology; endocrinology; gastroenterology; general surgery; nephrology; neurology; neurosurgery; otolaryngology; ophthalmology; orthopedics; oncology/hematology; psychiatry (adults); psychiatry (child/adolescent); and urology</p> <p><u>2. Essential Hospital Services:</u> Executed contract with at least one (1) tertiary care center for each essential hospital service</p> <p><u>3. Center of Excellence for People with AIDS:</u> Executed contract with at least two (2) Center of Excellence for AIDS within the CONTRACTOR's approved Grand Region(s)</p> <p><u>4. Center of Excellence for Behavioral Health:</u> Executed contract with all COEs for Behavioral Health within the CONTRACTOR's approved Grand Region(s)</p>	Executed contract is a signed provider agreement with a provider to participate in the CONTRACTOR's network as a contract provider	Monthly	<p>\$25,000 if ANY of the listed standards are not met, either individually or in combination on a monthly basis</p> <p>The liquidated damage may be waived for Physician Specialists if the CONTRACTOR provides sufficient documentation to demonstrate that the deficiency is attributable to a lack of physicians practicing in the area. The liquidated damage may be lowered to \$5,000 in the event the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE</p>

Amendment Number 22 (cont.)

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
13	HCBS Provider Network	Provider Enrollment File	Upon enrollment of members in CHOICES Group 2 and/or 3 (if and when directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3), at least two (2) providers for each HCBS, other than community-based residential alternatives, to cover each county in each applicable Grand Region	Executed contract is a signed provider agreement with a provider to participate in the CONTRACTOR's network as a contract provider	Quarterly	<p>Beginning after the first calendar quarter following enrollment of members in CHOICES Group 2 and/or 3 (as directed by TENNCARE) in a Grand Region, \$25,000 if ANY of the listed standards are not met, either individually or in combination on a quarterly basis</p> <p>The liquidated damage may be waived if the CONTRACTOR provides sufficient documentation to demonstrate that the deficiency is attributable to a lack of HCBS provider serving the county and the CONTRACTOR has used good faith efforts to develop HCBS providers to serve the county</p> <p>The liquidated damage may be lowered to \$5,000 in the event the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE</p>

Amendment Number 22 (cont.)

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
14	Provider Participation Accuracy	Provider Enrollment File	At least 90% of listed providers confirm participation in the CONTRACTOR's network	A statistically valid sample of participating providers on the most recent monthly provider enrollment file confirm that they are participating in the CONTRACTOR's network	Quarterly	\$25,000 per quarter if less than 90% of providers confirm participation. The liquidated damage may be lowered to \$5,000 in the event that the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE, or may be waived by TENNCARE if the CONTRACTOR submits sufficient documentation to demonstrate 90% of providers in the sample are participating
15	Provider Information Accuracy	Provider Enrollment File	Data for no more than 10% of listed providers is incorrect for <u>each</u> data element	Data for no more than 10% of a statistically valid sample of participating providers on the most recent monthly provider enrollment is incorrect for <u>each</u> element as determined by TENNCARE	Quarterly	\$5,000 per quarter if data for more than 10% but fewer than 31% of providers is incorrect for <u>each</u> data element \$25,000 per quarter if data for more than 30% of providers is incorrect for <u>each</u> data element The \$25,000 liquidated damage may be lowered to \$5,000 in the event that the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE, or may be waived by TENNCARE if the CONTRACTOR submits sufficient documentation

Amendment Number 22 (cont.)

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
16	Distance from provider to member	Provider Enrollment File	In accordance with this Agreement, including Attachments III through V	Time and travel distance as measured by GeoAccess	Monthly	<p>\$25,000 if ANY of the listed standards are not met, either individually or in combination, on a monthly basis</p> <p>The liquidated damage may be lowered to \$5,000 in the event that the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE</p> <p>For the first six months after being directed by TENNCARE to serve as a back-up health plan and/or enroll members in CHOICES Group 2 and/or 3, TENNCARE will waive the liquidated damage related to distance to adult day care if the CONTRACTOR demonstrates that it is providing NEMT to adult day care in accordance with Section 2.11.1.8. Thereafter, TENNCARE may waive the liquidated damage regarding distance to adult day care if the CONTRACTOR provides sufficient documentation to demonstrate that the deficiency is attributable to a lack of adult day care providers and the CONTRACTOR has used good faith efforts to develop adult day care providers.</p>

Amendment Number 22 (cont.)

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
17	Initial appointment timeliness for behavioral health services	Behavioral Health Initial Appointment Timeliness Report	85% of all initial appointments for behavioral health services for outpatient mental health services (MD and Non-MD) and outpatient substance abuse services shall meet the access and availability standards indicated in Attachment V	Average time between the intake assessment appointment and the member's next appointment scheduled or admission by type of service	Quarterly	\$2,000 for each service type for which less than 85% of all initial appointments for the specified provider types meet the access and availability standards indicated in Attachment V
18	Percentage of SPMI/SED members who receive a behavioral health service (excluding a CRG/TPG assessment)	Claims and encounter data	The percentage of SPMI/SED members who receive a behavioral health service (excluding a CRG/TPG assessment) will not be less than 76%	The number of SPMI/SED members receiving a behavioral health service (excluding a CRG/TPG assessment) during the fiscal year divided by the MCO's number of SPMI/SED members during the fiscal year is not less than the benchmark	Annually	\$25,000 for each year determined to not be in compliance
19	Non-IMD Inpatient Use	Behavioral Health Crisis Service Response Reports and utilization data	10% decrease of total inpatient days at freestanding psychiatric hospitals subject to IMD exclusion compared to the base year's utilization	Total inpatient psychiatric hospital days at IMD exclusion facilities for members reduced by 10% after base line year	Annually	\$10,000 for each year determined to not be in compliance
20	TENNderCare Screening	MCO encounter data	TENNderCare screening ratio, 80%	The EPSDT screening ratio, calculated by TENNCARE utilizing MCO encounter data submissions in accordance with specifications for the CMS-416 report	Quarterly	\$5,000 for each full percentage point TENNderCare screening ratio is below 80% for the most recent rolling twelve month period
21	Increase in utilization of supported employment	Supported Employment Reports	15% of all adults (21 – 64 years of age) designated as SPMI actively receiving supported employment services will be gainfully employed in either part time or full time capacity for a continuous 90 day period within one (1) year of receiving supported employment services	Total number of SPMI adults receiving supported employment services as defined in Attachment I employed for a continuous 90-day period within one (1) year of receiving supported employment services divided by the total number of SPMI adults	Annually	\$25,000 for each year determined to not be in compliance
22	Generic Prescription Drug Utilization	Encounter data	Sixty percent (60%)	Number of generic prescriptions divided by the total number of prescriptions	Quarterly	\$5,000 for each full percentage point Generic Prescription Utilization ratio is below 60%

Amendment Number 22 (cont.)

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
23	Length of time between psychiatric hospital/RTF discharge and first subsequent mental health case management service	Mental Health Case Management Report	90% of discharged members <i>receive</i> a mental health case management service as medically necessary within seven (7) calendar days of discharge, excluding situations involving member reschedules, no shows, and refusals	(1) Number of members discharged by length of time between discharge and first subsequent mental health case management service as medically necessary reported by CMHA and type of service received; determined for each month (2) Average length of time between hospital discharge and first subsequent medically necessary MHCM visit reported by CMHA and type of service received excluding member reschedules, no shows, and refusals; determined for each month	Quarterly	\$3,000 for each quarter determined to not be in compliance
24	Seven (7) day readmission rate	Psychiatric Hospital/RTF Readmission Report	Not more than 10% of members discharged from an inpatient or residential facility are readmitted within seven (7) calendar days of discharge	Number of members discharged from an inpatient or residential facility divided by the number of members readmitted within seven (7) calendar days of discharge; determined for each month in the quarter	Quarterly	\$1,500 for each quarter determined to not be in compliance
25	Thirty (30) day readmission rate	Psychiatric Hospital/RTF Readmission Report	Not more than 15% of members discharged from an inpatient or residential facility are readmitted within thirty (30) calendar days of discharge	Number of members discharged from an inpatient or residential facility divided by the number of members readmitted within thirty (30) calendar days of discharge; determined for each month in the quarter	Quarterly	\$1,500 for each quarter determined to not be in compliance
26	Members are satisfied with the services they receive from behavioral health providers	Annual consumer satisfaction survey administered by TDMHDD	85% of respondents rate their experience to be fair or better	Distribution of members by satisfaction score	Annually	\$10,000 for each response below 85%

54. **Delete Attachment VIII and replace with “Intentionally Left Blank.”**
55. **Attachment IX shall be amended by deleting Attachment IX in its entirety and replacing it with the following and renumbering all references thereto:**

ATTACHMENT IX - REPORTING REQUIREMENTS

ATTACHMENT IX, EXHIBIT A - INTENTIONALLY LEFT BLANK

ATTACHMENT IX, EXHIBIT B - MENTAL HEALTH CASE MANAGEMENT REPORT

The *Mental Health Case Management Report* required in Section 2.30.4.2 shall include, at a minimum, the following data elements:

1. MCO ID number
2. Number and percentage of compliance for appointments scheduled within 7 calendar days of the date of discharge from psychiatric inpatient or residential treatment facility
3. Number and percentage of compliance for appointments occurring within 7 calendar days of the date of discharge from psychiatric inpatient or residential treatment facility, excluding member no shows, reschedules, and refusals
4. Number and percentage of appointment no shows
5. Number and percentage of appointment reschedules
6. Number and percentage of members meeting medical necessity for mental health case management and refusing the service
7. Data elements #2 - #6 broken down by mental health case management agency
8. DCS status

ATTACHMENT IX, EXHIBIT C - BEHAVIORAL HEALTH CRISIS RESPONSE REPORT

The *Behavioral Health Crisis Response Report* required in Section 2.30.4.4 shall include, at a minimum, the following data elements:

1. Total Telephone Contacts
2. Type of Call: Psychiatric Emergency
3. Type of Call: Urgent
4. Type of Call: Routine
5. Total Face-to-Face Contacts
6. Face-to-Face Type: Psychiatric Emergency
7. Face-to-Face Type: Urgent
8. Face-to-Face Type: Routine
9. Total Face-to-Face Contacts by Payor
10. Face-to-Face Payor Source: TennCare
11. Face-to-Face Payor Source: Medicare
12. Face-to-Face Payor Source: Commercial
13. Face-to-Face Payor Source: None
14. Total Face-to-Face Contacts by Location
15. Face-to-Face Location: Onsite at CMHA
16. Face-to-Face Location: ER
17. Face-to-Face Location: Other Offsite
18. Total Face-to-Face Contacts by Disposition
19. Disposition: Total Admitted to RMHI (acute)
20. # Admitted to RMHI Not Mandatory Pre-Screened
21. Disposition: Total Admitted to Other Inpt (acute) Includes Dual Dx
22. # Admitted To Other Inpt Not Mandatory Pre-Screened
23. GRAND TOTAL PSYCHIATRIC ADMISSIONS

Amendment Number 22 (cont.)

24. Disposition: Admitted to IP SA Treatment
25. Disposition: Referred to Lower Level OP Care
26. Disposition: Referred to Respite Services
27. Average time for Admission to Crisis Respite (only when admitted to respite)
28. Disposition: Referred to Other Services
29. Disposition: Assessed / No Need for Referral
30. Disposition: Consumers Refusing Referral
31. Total Number of Face-to-Face Contacts for C&A <18 yrs of age
32. Total Number of Face-to-Face Contacts for C&A 18 to <21 yrs of age
33. Total Number of Face-to-Face Contacts for Adults 21 yrs and older
34. Total Number of Behavioral Health Providers notified of Crisis (only if consumer has a provider)
35. Average Time of Arrival in Minutes: Psychiatric Emergency
36. Average Time of Arrival in Minutes: Urgent
37. Barriers to Diversion: No Psychiatric Respite Accessible
38. Barriers to Diversion: No SA/Dual Respite Accessible
39. Barriers to Diversion: Consumer/Guardian Refused Respite
40. Barriers to Diversion: 6-404 Signed Prior to Assessment (when consumer could have been diverted if CON not signed)
41. Barriers to Diversion: Lack of Linkage w/Case Mgr (only if consumer has a CM)
42. Barriers to Diversion: Other (only for inappropriate admissions and barrier does not fit in any other category)

ATTACHMENT IX, EXHIBIT D - MEMBER CRG/TPG ASSESSMENT REPORT

The *Member CRG/TPG Assessment Report* required in Section 2.30.4.5 shall include, at a minimum, the following data elements:

CRG assessment of members age 18 years or older

1. MCO's ID number
2. Member's last name
3. Member's first name
4. Member's birth date
5. Member's Social Security Number (SSN)
6. Principal diagnosis
7. Dual principal/secondary diagnosis
8. Measure of member's level of functioning in activities of daily living
9. Measure of member's level of functioning in interpersonal functioning
10. Measure of member's level of functioning in concentration, task performance, and pace
11. Measure of member's level of functioning in adaptation to change
12. Measure of member's severity of impairment
13. Measure of member's duration of mental illness
14. Indicator of member's former severe impairment
15. Member's need for services to prevent relapse
16. Member's Clinically Related Group (CRG)
17. Reason for assessment
18. Date of request for assessment
19. Date of CRG assessment
20. Measure of rater's adequacy of information in order to complete assessment
21. Member's current Global Assessment of Functioning (GAF) scale score
22. Member's highest GAF scale score (past year)
23. Member's lowest GAF scale score (past year)
24. Program code
25. Rater's TennCare provider ID number

Amendment Number 22 (cont.)

TPG assessment of members under age 18

1. MCO's ID number
2. Member's last name
3. Member's first name
4. Member's date of birth
5. Member's social security number
6. Principal diagnosis
7. Dual principal/secondary diagnosis
8. Member's current Global Assessment of Functioning (GAF) scale score
9. Member's highest GAF scale score (past year)
10. Member's lowest GAF scale score (past year)
11. Severity of impairment
12. Serious Emotional Disturbance (SED) status
13. Environmental issues
14. Family issues
15. Trauma issues
16. Social skills issues
17. Abuse/neglect issues
18. Child at risk of SED
19. Member's Target Population Group (TPG)
20. Reason for assessment
21. Date of request for assessment
22. Date of TPG assessment
23. Measure of rater's adequacy of information in order to complete assessment
24. Program code
25. Rater's TennCare provider ID number

ATTACHMENT IX, EXHIBIT E - INTENTIONALLY LEFT BLANK

ATTACHMENT IX, EXHIBIT F - INTENTIONALLY LEFT BLANK

ATTACHMENT IX, EXHIBIT G - REPORT OF ESSENTIAL HOSPITAL SERVICES

Instructions for Completing *Report of Essential Hospital Services*

The chart for the *Report of Essential Hospital Services* required in Section 2.30.7.4 is to be prepared based on the CONTRACTOR's provider network for essential hospital services in each Grand Region in which the CONTRACTOR has (or expects to have) TennCare members.

- Fill out one report for each Grand Region. In the top portion of the grid, indicate the MCO name, the Grand Region, the total number of MCO members in the Grand Region and the date that such total enrollment was established.
- Provide information on each contract and non-contract facility that serves (or will serve) members in the identified Grand Region. The MCO should use a separate row to report information on each such facility.

1. In the first column, "Name of Facility" indicate the complete name of the facility.
2. In the second column, "TennCare ID" indicate the TennCare ID assigned to the facility.
3. In the third column, "NPI" indicate the National Provider Identifier issued to the facility.

Amendment Number 22 (cont.)

4. In the fourth column, “City/Town” indicate the city or town in which the designated facility is located.
5. In the fifth column, “County”, indicate the name of the county in which this facility is located.
6. In the sixth through the thirteenth columns indicate the status of the CONTRACTOR’s relationship with the specific facility for each of these covered hospital services, e.g. Neonatal, Perinatal, Pediatric, Trauma, Burn, Center of Excellence for AIDS, Center of Excellence for Children at Risk or in State Custody and Centers of Excellence for Behavioral Health. For example:
 - If the CONTRACTOR has an executed provider agreement with the facility for neonatal services, insert an “E” in the column labeled “Neonatal”.
 - If the CONTRACTOR does not have an executed provider agreement with this facility for “Neonatal”, but has another type of arrangement with this facility, the CONTRACTOR should indicate the code that best describes its relationship (L=letter of intent; R=on referral basis; N=in contract negotiations; O=other arrangement). For any facility in which the CONTRACTOR does not have an executed provider agreement and is using as a non-contract provider, the CONTRACTOR should submit a brief description (one paragraph) of its relationship with the facility including an estimated timeline for executing a provider agreement, if any.
 - If the CONTRACTOR does not have any relationship for neonatal services with the facility on this row, the CONTRACTOR should leave the cell labeled “neonatal” blank.

**ATTACHMENT IX, EXHIBIT G
ESSENTIAL HOSPITAL SERVICES REPORT**

MCO Name: _____

Grand Region: _____

Number of TennCare Members: _____

as of (date): _____

Name of Facility	TennCare ID	NPI	City/ Town	County	Neonatal	Perinatal	Pediatric	Trauma	Burn	AIDS Center of Excellence	Center of Excellence for Children at Risk or in State Custody	Center of Excellence for Behavioral Health	Comments

- E = Executed Provider Agreement
- L = Letter of Intent
- R = On Referral Basis
- N = In Contract Negotiations
- O = Other Arrangement

If no relationship for a particular service leave cell blank

ATTACHMENT IX, EXHIBIT H - FQHC REPORT

MCO Name: _____

As of January 1, _____

Please provide the information identified below for each FQHC with which the MCO has a provider agreement.

1. FQHC Name: _____
2. FQHC Address: _____

3. Total Amount Paid for the previous twelve (12) month period from July 1 through June 30: _____

ATTACHMENT IX, EXHIBIT I - SINGLE CASE AGREEMENTS REPORT

MCO Name: _____

Month/Year: _____

Date of Agreement	Name of Member	Name of Provider	Specialty	Service Reason	Amount to be Paid

ATTACHMENT IX, EXHIBIT J - INTENTIONALLY LEFT BLANK

ATTACHMENT IX, EXHIBIT K - COST AND UTILIZATION SUMMARIES

The quarterly *Cost and Utilization Summaries* required in Section 2.30.10.3 shall include the following:

- 1) Data elements for *Top 25 Providers (broken down by facilities, practitioners, ancillary providers, transportation providers) by Amount Paid*
 - Rank
 - Provider type
 - Provider Name
 - Street Address (Physical Location)
 - City
 - State
 - Zip Code
 - Amount Paid to Each Provider
 - Amount Paid as a Percentage of Total Provider Payments
- 2) Data elements for *Top 25 Inpatient Diagnoses by Number of Admissions*
 - Rank
 - DRG Code (Diagnosis Code)
 - Description
 - Amount Paid
 - Admits
 - Admits as a Percentage of Total Admits
- 3) Data elements for *Top 25 Inpatient Diagnoses by Amount Paid*
 - Rank
 - DRG Code (Diagnosis Code)
 - Description
 - Admits
 - Amount Paid
 - Amount Paid as a Percentage of Total Inpatient Dollars
- 4) Data elements for *Top 25 Outpatient Diagnoses by Number of Visits*
 - Rank
 - Diagnosis code
 - Description
 - Amount Paid
 - Visits
 - Visits as a percentage of Total Outpatient Visits
- 5) Data elements for *Top 25 Outpatient Diagnoses by Amount Paid*
 - Rank
 - Diagnosis Code
 - Description
 - Visits
 - Amount Paid
 - Amount Paid as a Percentage of Total Outpatient Payments

Amendment Number 22 (cont.)

- 6) Data elements for *Top 10 Inpatient Surgical/Maternity Procedures (DRGs) by Number of Admissions*
 - Rank
 - DRG Code
 - Description
 - Amount Paid
 - Number of Admissions
 - Admissions as a Percentage of Total Admissions

- 7) Data elements for *Top 10 Inpatient Surgical/Maternity Procedures (DRGs) by Amount Paid*
 - Rank
 - DRG Code
 - Description
 - Number of Procedures
 - Amount Paid
 - Amount Paid as a Percentage of Total Inpatient Surgical/Maternity Payments

- 8) Data elements for *Top 10 Outpatient Surgical/Maternity Procedures by Number of Procedures*
 - Rank
 - Procedure Code
 - Description
 - Amount Paid
 - Number of Procedures
 - Procedures as a Percentage of Total Surgical/Maternity Procedures

- 9) Data elements for *Top 10 Outpatient Surgical/Maternity Procedures by Amount Paid*
 - Rank
 - Procedure Code
 - Description
 - Number of Procedures
 - Amount Paid
 - Amount Paid as a Percentage of Total Outpatient Surgical/Maternity Payments

ATTACHMENT IX, EXHIBIT L - INTENTIONALLY LEFT BLANK

ATTACHMENT IX, EXHIBIT M - MEMBER SERVICES, PROVIDER SERVICES, AND UTILIZATION MANAGEMENT PHONE LINE REPORT

Instructions for Completing the Member Services, Provider Services, and Utilization Management Phone Line Report

The following definitions shall be used:

Abandoned Call: A call in the phone line queue that is terminated by the caller before reaching a live voice.

Average Time to Answer: The average time that callers waited in the phone line queue (when the call was placed during the hours the phone line is open for services) before speaking to a MCO representative. This shall be reported in minutes: seconds (e.g. one minute and twenty-five seconds should be reported as 1:25).

Call Abandonment Rate: The number of calls (where the member/provider called directly into the phone line or selected a member/provider services option and was put in the call queue) that are abandoned by the caller or the system before being answered by a live voice, divided by the number of calls received by the phone line (during hours when the line is staffed with personnel - hours open for services) during the measurement period.

Call Answer Timeliness: The number of calls (where the member called directly into the phone line or selected a member/provider services option and was put in the call queue) that are answered by a live voice within thirty (30) seconds, divided by the number of calls received by the phone line (during hours when the line is staffed with personnel - hours open for services) during the measurement period.

**ATTACHMENT IX, EXHIBIT M
MEMBER SERVICES, PROVIDER SERVICES, AND UTILIZATION MANAGEMENT
PHONE LINE REPORT**

MCO Name: _____

Report Submission Date: _____

Reporting Quarter: _____

		[Month 1]	[Month 2]	[Month 3]
Member Services Line	Total Number of Calls Received			
	% of Calls Abandoned			
	Average Time to Answer			
	% of Calls Answered within 30 Seconds			
Nurse Triage Line	Total Number of Calls Received			
	% of Calls Abandoned			
	Average Time to Answer			
	% of Calls Answered within 30 Seconds			
Provider Services Line	Total Number of Calls Received			
	% of Calls Abandoned			
	Average Time to Answer			
	% of Calls Answered within 30 Seconds			
Utilization Management Line	Total Number of Calls Received			
	% of Calls Abandoned			
	Average Time to Answer			
	% of Calls Answered within 30 Seconds			

ATTACHMENT IX, EXHIBIT N - IMMEDIATE ELIGIBILITY INVOICE

VOLUNTEER STATE HEALTH PLAN, INC.
CUMULATIVE BILLING SUMMARY FOR DCS CHILDREN NOT TENNCARE ELIGIBLE
 For the Period _____, Through _____, with Information Received Through _____

Month	Claims Paid	Number of Members Termed	Administrative Fee	Amount Received	Amount Due
January	\$ -	2	\$87.36	\$ -	\$ 87.36
February	-	8	349.44	-	349.44
March	-	9	393.12	-	393.12
April	-	25	1,092.00	-	1,092.00
May	-	31	1,354.08	-	1,354.08
June	-	24	1,048.32	-	1,048.32
July	-	28	1,223.04	-	1,223.04

Total	\$ -	127	\$ 5,547.36	\$ -	\$ 5,547.36
--------------	------	-----	-------------	------	-------------

Net Due

\$
5,547.36

Claims Paid

Represents claim paid during the month noted. A detail report by date of service and date paid is also attached. These claims have already been paid and, as such, the total represents the amount DCS needs to reimburse the Bureau of TennCare.

Number of Members Termed

Represents a count of the number of members whose eligibility termed during the noted month.

Administrative Fee

The agreed upon flat administrative fee owed for each unique member span.

Net Due

Current amount of Administrative Fee owed to VSHP. (Administrative Fee less Amount Received)

VOLUNTEER STATE HEALTH PLAN, INC.
CUMULATIVE BILLING SUMMARY FOR DCS CHILDREN NOT TENNCARE ELIGIBLE
 For the Period _____, Through _____, with Information Received Through _____

Month	Claims Paid	Number of Members Termed	Administrative Fee	Amount Received	Amount Due
January	\$ -	2	\$ 87.36	\$ -	\$ 87.36
February	-	8	349.44	-	349.44
March	-	9	393.12	-	393.12
April	-	25	1,092.00	-	1,092.00
May	-	31	1,354.08	-	1,354.08
June	-	24	1,048.32	-	1,048.32
July	-	28	1,223.04	-	1,223.04
Total	\$ -	127	\$ 5,547.36	\$ -	\$ 5,547.36

Net Due

\$ 5,547.36

Claims Paid

Represents claim paid during the month noted. A detail report by date of service and date paid is also attached. These claims have already been paid and, as such, the total represents the amount DCS needs to reimburse the Bureau of TennCare.

Number of Members Termed

Represents a count of the number of members whose eligibility terminated during the noted month.

Administrative Fee

The agreed upon flat administrative fee owed for each unique member span.

Net Due

Current amount of Administrative Fee owed to VSHP. (Administrative Fee less Amount Received)

VOLUNTEER STATE HEALTH PLAN, INC.
CLAIMS PAID FOR DCS CHILDREN NOT TENNCARE ELIGIBLE

For the Period _____, Through _____, with Information Received Through _____

Paid Month	Date of Service Month												Total Paid	
	January 2003	February 2003	March 2003	April 2003	May 2003	June 2003	July 2003	August 2003	September 2003	October 2003	November 2003	December 2003		
January 2003	\$ -													\$ -
February 2003	\$ -	\$ -												\$ -
March 2003	\$ -	\$ -	\$ -											\$ -
April 2003	\$ -	\$ -	\$ -	\$ -										\$ -
May 2003	\$ -	\$ -	\$ -	\$ -	\$ -									\$ -
June 2003	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -								\$ -
July 2003	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -							\$ -
August 2003	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -						\$ -
September 2003	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -					\$ -
October 2003	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -				\$ -
November 2003	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -			\$ -
December 2003	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		\$ -
	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

Amendment Number 22 (cont.)

VOLUNTEER STATE HEALTH PLAN, INC.
ADMINISTRATIVE FEE FOR DCS CHILDREN NOT TENNCARE ELIGIBLE

For the Period _____, Through _____, with Information Received Through _____

Member Number	Member Name	Effective Date	Term Date	01	02	03	04	05	06	07	Month	Total Days	Administrative Fee
123456885		06/26/2002	07/02/2002	0	0	0	0	0	5	2	200207	7	43.68
123456886		04/12/2002	04/16/2002	0	0	0	5	0	0	0	200204	5	43.68
123456887		04/26/2002	04/30/2002	0	0	0	5	0	0	0	200204	5	43.68
123456888		05/23/2002	05/27/2002	0	0	0	0	5	0	0	200205	5	43.68
123456889		05/23/2002	05/27/2002	0	0	0	0	5	0	0	200205	5	43.68
123456890		02/08/2002	02/11/2002	0	4	0	0	0	0	0	200202	4	43.68
123456891		02/19/2002	02/22/2002	0	4	0	0	0	0	0	200202	4	43.68
123456892		05/20/2002	05/23/2002	0	0	0	0	4	0	0	200205	4	43.68
123456893		06/21/2002	06/24/2002	0	0	0	0	0	4	0	200206	4	43.68
123456894		06/21/2002	06/24/2002	0	0	0	0	0	4	0	200206	4	43.68
123456895		06/21/2002	06/24/2002	0	0	0	0	0	4	0	200206	4	43.68
123456896		06/21/2002	06/24/2002	0	0	0	0	0	4	0	200206	4	43.68
123456897		02/05/2002	02/07/2002	0	3	0	0	0	0	0	200202	3	43.68
123456898		02/05/2002	02/07/2002	0	3	0	0	0	0	0	200202	3	43.68
123456899		02/11/2002	02/13/2002	0	3	0	0	0	0	0	200202	3	43.68
123456900		03/18/2002	03/20/2002	0	0	3	0	0	0	0	200203	3	43.68
123456901		03/22/2002	03/24/2002	0	0	3	0	0	0	0	200203	3	43.68
123456902		04/05/2002	04/07/2002	0	0	0	3	0	0	0	200204	3	43.68
123456903		04/22/2002	04/24/2002	0	0	0	3	0	0	0	200204	3	43.68
123456904		05/31/2002	06/02/2002	0	0	0	0	1	2	0	200206	3	43.68
123456905		01/30/2002	01/31/2002	2	0	0	0	0	0	0	200201	2	43.68
123456906		03/17/2002	03/18/2002	0	0	2	0	0	0	0	200203	2	43.68
123456907		04/29/2002	04/30/2002	0	0	0	2	0	0	0	200204	2	43.68
123456908		04/30/2002	05/01/2002	0	0	0	1	1	0	0	200205	2	43.68
123456909		05/20/2002	05/21/2002	0	0	0	0	2	0	0	200205	2	43.68
123456910		03/12/2002	03/12/2002	0	0	1	0	0	0	0	200203	1	43.68
123456911		03/19/2002	03/19/2002	0	0	1	0	0	0	0	200203	1	43.68
123456912		06/22/2002	06/22/2002	0	0	0	0	0	1	0	200206	1	43.68
123456913		07/17/2002	07/17/2002	0	0	0	0	0	0	1	200207	1	43.68
123456914		07/23/2002	07/23/2002	0	0	0	0	0	0	1	200207	1	43.68
123456915		07/31/2002	07/31/2002	0	0	0	0	0	0	1	200207	1	43.68
127	Total			54	300	703	939	1,038	821	426	-	4,281	\$ 5,547.36

56. Attachment X shall be amended by deleting Attachment X in its entirety and replacing it with the following and renumbering all references thereto:

**ATTACHMENT X
ATTESTATION RE PERSONNEL USED IN CONTRACT PERFORMANCE**

SUBJECT CONTRACT NUMBER:	
CONTRACTOR LEGAL ENTITY NAME:	
FEDERAL EMPLOYER IDENTIFICATION NUMBER: (or Social Security Number)	

The Contractor, identified above, does hereby attest, certify, warrant, and assure that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract.

CONTRACTOR SIGNATURE

NOTICE: This attestation MUST be signed by an individual empowered to contractually bind the Contractor. If said individual is not the chief executive or president, this document shall attach evidence showing the individual's authority to contractually bind the Contractor.

PRINTED NAME AND TITLE OF SIGNATORY

DATE OF ATTESTATION

- 57. Attachment XI shall amended by deleting Attachment XI in its entirety and replacing it with the following and renumbering all references thereto:**

**ATTACHMENT XI
NEMT REQUIREMENTS**

A.1 GENERAL

- A.1.1 The CONTRACTOR, in its delivery of NEMT services, shall comply with all of the requirements in this Attachment XI. The requirements in this Attachment are in addition to, not instead of, requirements found elsewhere in the Agreement.
- A.1.2 The CONTRACTOR shall develop written policies and procedures that describe how the CONTRACTOR, in the delivery of NEMT services, shall comply with the requirements of the Agreement, including this Attachment. These policies and procedures must be prior approved in writing by TENNCARE. As part of its policies and procedures the CONTRACTOR shall develop an operating procedures manual detailing procedures for meeting, at a minimum, requirements regarding the following:
- A.1.2.1 Requesting NEMT services (see Section A.3 of this Attachment);
 - A.1.2.2 Approving NEMT services (see Section A.4 of this Attachment); and
 - A.1.2.3 Scheduling, assigning and dispatching trips (see Section A.5 of this Attachment).

A.2 NEMT IMPLEMENTATION WORK PLAN AND READINESS REVIEW

- A.2.1 The CONTRACTOR shall implement the NEMT requirements of the Agreement, including this Attachment XI, in two phases. Phase One shall include the requirements specified by TENNCARE, which shall include but not be limited to vehicle and driver standards in Section A.7 and Section A.8 of this Attachment XI. Phase Two shall include all NEMT requirements of the Agreement that are not included in Phase One.
- A.2.2 By no later than May 1, 2008 the CONTRACTOR shall submit to TENNCARE for prior written approval an implementation work plan that details all of the tasks required to successfully implement all of the NEMT requirements of the Agreement, including both Phase One and Phase Two requirements. By September 1, 2008, the CONTRACTOR shall have fully implemented the implementation work plan for Phase One, and the CONTRACTOR may be subject to liquidated damages for failure to comply with the applicable provisions herein. The CONTRACTOR shall have fully implemented all NEMT requirements of the Agreement by the date specified by TENNCARE, which shall be no earlier than September 1, 2008, and at that time the CONTRACTOR may be subject to liquidated damages for failure to comply with any of the provisions herein.
- A.2.3 Prior to implementation of any of the NEMT requirements in this Attachment, as determined by TENNCARE, the CONTRACTOR shall demonstrate to TENNCARE's satisfaction that the CONTRACTOR is able to meet the NEMT requirements specified by TENNCARE.
- A.2.4 The CONTRACTOR shall cooperate in "readiness reviews" conducted by TENNCARE to review the CONTRACTOR's readiness to implement any or all of the NEMT requirements of the

Agreement. These reviews may include, but are not limited to, desk and on-site review of documents provided by the CONTRACTOR, a walk-through of the CONTRACTOR's operations, system demonstrations (including systems connectivity testing), and interviews with CONTRACTOR's staff.

A.2.5 Based on the results of the review activities, TENNCARE will issue a letter of findings and, if needed, will request a corrective action plan from the CONTRACTOR.

A.3 **REQUESTING NEMT SERVICES**

A.3.1 Members or their representatives shall be allowed to make requests for NEMT services on behalf of members. For DCS enrollees (as defined in Exhibit A of this Attachment), representatives include the member's DCS liaison, foster parent, adoptive parent, or provider.

A.3.2 Requests for NEMT services should be made at least seventy-two (72) hours before the NEMT service is needed. However, this timeframe does not apply to urgent trips (see Section A.5.7 of this Attachment), scheduling changes initiated by the provider, and follow-up appointments when the timeframe does not allow advance scheduling. In addition, the CONTRACTOR shall accommodate requests for NEMT services that are made within the following timeframes: three (3) hours before the NEMT service is needed when the pick-up address is in an urban area and four (4) hours before the NEMT service is needed when the pick-up address is in a non-urban area. The CONTRACTOR shall provide additional education to members who fail to request transportation seventy-two (72) hours before the NEMT service is needed (see Section A.10 of this Attachment).

A.3.3 The CONTRACTOR shall not have a time limit for scheduling transportation for future appointments. For example, if a member calls to schedule transportation to an appointment that is scheduled in two (2) months, the CONTRACTOR shall arrange for that transportation and shall not require the member to call back at a later time.

A.4 **APPROVING NEMT SERVICES**

A.4.1 **General**

A.4.1.1 Transportation for a minor child shall not be denied pursuant to any policy that poses a blanket restriction due to member's age or lack of accompanying adult. Any decision to deny transportation of a minor child due to a member's age or lack of an accompanying adult shall be made on a case-by-case basis and shall be based on the individual facts surrounding the request and State of Tennessee law. Tennessee recognizes the "mature minor exception" to permission for medical treatment. The age of consent for children with mental illness is sixteen (16) (see TCA 33-8-202).

A.4.1.2 As part of the approval process, the CONTRACTOR shall:

A.4.1.2.1 Collect relevant information from the caller and enter it into the CONTRACTOR's system (see Section A.5.10 of this Attachment);

A.4.1.2.2 Verify the member's eligibility for NEMT services;

A.4.1.2.3 Determine the appropriate mode of transportation for the member;

Amendment Number 22 (cont.)

- A.4.1.2.4 Determine the appropriate level of service for the member;
- A.4.1.2.5 Approve or deny the request; and
- A.4.1.2.6 Enter the appropriate information into the CONTRACTOR's system (see Section A.5.10 of this Attachment).

A.4.2 Verifying Eligibility for NEMT Services

- A.4.2.1 The CONTRACTOR shall screen all requests for NEMT services to confirm each of the following items:
 - A.4.2.1.1 That the person for whom the transportation is being requested is a TennCare enrollee and enrolled in the CONTRACTOR's MCO;
 - A.4.2.1.2 That the service for which NEMT service is requested is a TennCare covered service (as defined in Exhibit A of this Attachment); and
 - A.4.2.1.3 That the transportation is a covered NEMT service (see Section 2.6.1.3 of the Agreement).

A.4.3 Determining the Appropriate Mode of Transportation

A.4.3.1 General

- A.4.3.1.1 If the criteria in Section A.4.2 of this Attachment are met, the CONTRACTOR shall determine what mode of transportation is appropriate to meet the needs of the member. The modes of transportation that shall be covered by the CONTRACTOR include, but are not limited to: fixed route, multi-passenger van, wheelchair van, invalid vehicle, and ambulance.
- A.4.3.1.2 In order to determine the appropriate mode of transportation, the CONTRACTOR shall:
 - A.4.3.1.2.1 Determine whether the member is ambulatory and the member's current level of mobility and functional independence;
 - A.4.3.1.2.2 Determine whether the member will be accompanied by an escort, and, if so, whether the member requires assistance and whether the escort meets the requirements for an escort (see TennCare rules and regulations);
 - A.4.3.1.2.3 Determine whether a member is under the age of eighteen (18) and will be accompanied by an adult; and
 - A.4.3.1.2.4 Assess any special conditions or needs of the member, including physical or mental disabilities.

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A.4.3.2 Fixed Route

A.4.3.2.1 The CONTRACTOR shall utilize fixed route transportation whenever available and appropriate to meet the needs of the member.

A.4.3.2.2 The CONTRACTOR shall be familiar with schedules of fixed route transportation in communities where it is available and where it becomes available during the term of the Agreement.

A.4.3.2.3 The CONTRACTOR shall distribute and/or arrange for the distribution of fixed route tickets, tokens or passes to members for whom fixed route transportation is available and appropriate. The CONTRACTOR shall have controls in place to track the distribution of tickets/tokens/passes. The CONTRACTOR shall use best efforts that tickets/tokens/passes are used appropriately.

A.4.3.2.4 The CONTRACTOR shall consider the following when determining whether fixed route transportation is available and appropriate for a member:

A.4.3.2.4.1 The furthest distance a member shall be required to travel to or from a fixed route transportation stop is one-quarter (1/4th) of a mile;

A.4.3.2.4.2 The member shall not be required to change buses/trolleys more than once each leg of the trip;

A.4.3.2.4.3 Using fixed route transportation shall not increase travel time more than sixty (60) minutes as compared to transportation directly from the pick-up location to the drop-off destination;

A.4.3.2.4.4 The fixed route transportation schedule shall allow the member to arrive at the destination no more than sixty (60) minutes prior to the scheduled appointment time and shall be flexible on the return so that the member does not have to wait at the pick-up location more than sixty (60) minutes after the estimated time the appointment will end;

A.4.3.2.4.5 Whether fixed route transportation is appropriate based on the member's physical or mental disabilities; and

A.4.3.2.4.6 Whether using fixed route for the requested trip is appropriate considering the accessibility of the stops and the safety in accessing the stops.

A.4.3.2.5 Fixed route shall not be appropriate for a member whose physician states in writing that the member cannot use fixed route transportation.

A.4.3.3 Ambulance

The CONTRACTOR's policies and procedures regarding the appropriateness of using an ambulance to provide covered NEMT services shall be based on Medicare's medical necessity requirements (see, e.g., 42 CFR 410.40 and Medicare Benefit Policy Manual, Chapter 10 - Ambulance Services).

A.4.4 Determining Level of Service

- A.4.4.1 The CONTRACTOR shall assess the member's needs to determine whether the member requires curb-to-curb, door-to-door, or hand-to-hand service (as these terms are defined in Exhibit A of this Attachment).
- A.4.4.2 The CONTRACTOR may require a medical certification statement from the member's provider in order to approve door-to-door or hand-to-hand service. Medical certification shall be completed within the timeframes specified in Section A.5.1.3 of this Attachment.
- A.4.4.3 The CONTRACTOR shall ensure that members receive the appropriate level of service.
- A.4.4.4 Failure to comply with requirements regarding level of service may result in liquidated damages as provided in Section 5.20.2 of the Agreement, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

A.4.5 Standing Orders

- A.4.5.1 Except as provided in this Section A.4.5, the approval of Standing Orders by the CONTRACTOR shall be consistent with the requirements in Sections A.4.1 through A.4.4.
- A.4.5.2 In order to approve a Standing Order (as defined in Exhibit A of this Attachment), the CONTRACTOR shall, at a minimum, call the provider to verify the series of appointments. The CONTRACTOR may, at its discretion, require that the member's provider certify the series of appointments in writing.
- A.4.5.3 The CONTRACTOR shall approve Standing Orders consistent with the series of appointments. For example, if the member has a series of appointments over six (6) months, the CONTRACTOR shall approve transportation for each trip, including all legs of the trip, for the six (6) months. However, the CONTRACTOR shall verify the member's eligibility prior to each pick-up. The CONTRACTOR may verify additional information before each pick-up as necessary.

A.4.6 Validating Requests

- A.4.6.1 The CONTRACTOR may conduct random pre-transportation validation checks prior to approving the request in order to prevent fraud and abuse.
- A.4.6.2 The CONTRACTOR may verify the need for an urgent trip with the provider prior to approving the trip.
- A.4.6.3 If requested by TENNCARE, the CONTRACTOR shall conduct pre-transportation validation checks of trips requested by specified members and/or to specific services or providers.
- A.4.6.4 All pre-transportation validation checks shall be conducted within the timeframes specified in Section A.5.1.3 of this Attachment.

A.5 SCHEDULING, ASSIGNING, AND DISPATCHING TRIPS

A.5.1 General

- A.5.1.1 The CONTRACTOR shall ensure that covered NEMT services are available twenty-four (24) hours a day, three hundred and sixty-five (365) days a year.
- A.5.1.2 After approving a NEMT service to be provided by a NEMT provider (i.e., not fixed route), the CONTRACTOR shall schedule and assign the trip to an appropriate NEMT provider.
- A.5.1.3 The CONTRACTOR shall approve and schedule or deny a request for transportation (including all legs of the trip) within twenty-four (24) hours of receiving the request. This timeframe shall be reduced as necessary to ensure the member arrives in time for his/her appointment. Failure to comply with this requirement may result in liquidated damages as provided in Section 5.20.2 of the Agreement, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.
- A.5.1.4 The CONTRACTOR shall ensure that trips are dispatched appropriately and meet the requirements of this Attachment. The dispatcher shall, at minimum, provide updated information to drivers, monitor drivers' locations, and resolve pick-up and delivery issues.

A.5.2 Multi-Passenger Transportation

- A.5.2.1 The CONTRACTOR may group enrollees and trips (or legs of trips) to promote efficiency and cost effectiveness. The CONTRACTOR may contact providers if necessary to coordinate multi-passenger transportation.
- A.5.2.2 For multi-passenger trips, the CONTRACTOR shall schedule each trip leg so that a member does not remain in the vehicle for more than one (1) hour longer than the average travel time for direct transportation of that member.

A.5.3 Choice of NEMT Provider

The CONTRACTOR is not required to use a particular NEMT provider or driver requested by the member. However, the CONTRACTOR may accommodate a member's request to have or not have a specific NEMT provider or driver.

A.5.4 Notifying Members of Arrangements

If possible, the CONTRACTOR shall inform the member of the transportation arrangements (see below) during the phone call requesting the NEMT service. Otherwise, the CONTRACTOR shall obtain the member's preferred method (e.g., phone call, email, fax) and time of contact, and the CONTRACTOR shall notify the member of the transportation arrangements (see below) as soon as the arrangements are in place (within the timeframe specified in Section A.5.1.3 of this Attachment) and prior to the date of the NEMT service. Information about transportation arrangements shall include but not be limited to the name and telephone number of the NEMT provider, the scheduled time and address of pick-up, and the name and address of the provider to whom the member seeks transport.

A.5.5 Notifying NEMT Providers

- A.5.5.1 The CONTRACTOR shall provide a trip manifest to each NEMT provider no later than the NEMT provider's close of business the day before the date of the NEMT service.
- A.5.5.2 The CONTRACTOR shall have the ability to send trip manifests to a NEMT provider by a facsimile device or secure electronic transmission, at the option of the NEMT provider. The CONTRACTOR shall ensure that provision of the trip manifest is in compliance with HIPAA requirements (see Section 2.27 of the Agreement). The CONTRACTOR shall have dedicated telephone lines available at all times for faxing purposes.
- A.5.5.3 The trip manifests supplied to NEMT providers shall include all necessary information for the driver to perform the trip, including but not limited to the information listed in Exhibit B of this Attachment.
- A.5.5.4 If the CONTRACTOR notifies a NEMT provider of a trip assignment after the timeframe specified in Section A.5.5.1, the CONTRACTOR shall also contact the NEMT provider by telephone or electronically to confirm that the trip will be accepted.
- A.5.5.5 The CONTRACTOR shall communicate information regarding cancellations to the NEMT provider in an expeditious manner to avoid unnecessary trips.

A.5.6 Accommodating Scheduling Changes

- A.5.6.1 The CONTRACTOR shall accommodate unforeseen schedule changes and shall timely assign the trip to another NEMT provider if necessary.
- A.5.6.2 The CONTRACTOR shall ensure that neither NEMT providers nor drivers change the assigned pick-up time without permission from the CONTRACTOR.

A.5.7 Urgent Trips

For urgent trips (as defined in Exhibit A of this Attachment), the CONTRACTOR shall contact an appropriate NEMT provider so that pick-up occurs within three (3) hours after the CONTRACTOR was notified when the pick-up address is in an urban area and four (4) hours after the CONTRACTOR was notified when the pick-up address is in a non-urban area. As provided in Section A.4.6.2 of this Agreement, the CONTRACTOR may verify the need for an urgent trip. Failure to comply with requirements regarding urgent trips may result in liquidated damages as provided in Section 5.20.2 of the Agreement, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

A.5.8 Adverse Weather Plan

The CONTRACTOR shall have policies and procedures for transporting members who need critical medical care, including but not limited to renal dialysis and chemotherapy, during adverse weather conditions. "Adverse weather conditions" includes, but is not limited to, extreme heat, extreme cold, flooding, tornado warnings and heavy snowfall. The policies and procedures shall include, at a minimum, staff training, methods of notification, and member education.

A.5.9 Contingency and Back-Up Plans

The CONTRACTOR shall have policies and procedures that describe contingency plans for unexpected peak transportation demands and back-up plans for instances when a vehicle is excessively late (more than twenty (20) minutes late) or is otherwise unavailable for service.

A.5.10 Approval and Scheduling System Features

- A.5.10.1 Each transportation request processed by the CONTRACTOR shall be assigned a unique number, shall contain all pertinent information about the request, and shall be available to NEMT Call Center staff. This information shall include, but not be limited to the following:
 - A.5.10.1.1 Verification of member's TennCare eligibility (e.g., member name, address, Medicaid ID number, and telephone number if available; eligibility start and end dates);
 - A.5.10.1.2 Determination that service is a TennCare covered service (e.g., category of service) (see Section A.4.2 of this Attachment);
 - A.5.10.1.3 Determination that the transportation is a covered NEMT service (see Section A.4.2 of this Attachment);
 - A.5.10.1.4 Determination of the appropriate mode of transportation (e.g., member's requested mode of transportation, member's special needs, availability and appropriateness of fixed route, the approved mode of transportation, justification for the approved mode of transportation);
 - A.5.10.1.5 Determination of the appropriate level of service (see Section A.4.4 of this Attachment);
 - A.5.10.1.6 Information regarding Standing Orders (if applicable) (see Section A.4.5 of this Attachment);
 - A.5.10.1.7 Information about whether the request was modified, approved or denied and how the member was notified;
 - A.5.10.1.8 Information about approved and scheduled transportation (e.g., elements required for the trip manifest; see Section A.5.5 of this Attachment);
 - A.5.10.1.9 Whether the request was validated;
 - A.5.10.1.10 Timeframes for the approval process (e.g., date and time of request, determination, scheduling, and notification of member); and
 - A.5.10.1.11 If applicable, reason for trip cancellation.
- A.5.10.2 The CONTRACTOR's approval and scheduling systems shall be coded such that policies and procedures are applied consistently.

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- A.5.10.3 Based on approval of previous NEMT services, the CONTRACTOR shall display members' permanent and temporary special needs, appropriate mode of transportation, and any other information necessary to ensure that appropriate transportation is approved and provided. All of this information shall be easily accessible by all NEMT Call Center staff.
- A.5.10.4 The CONTRACTOR's approval and scheduling systems shall also support the following:
 - A.5.10.4.1 A database of NEMT providers that includes information needed to determine trip assignments such as but not limited to: types of vehicles, number of vehicles by type, lift capacity of vehicles, and geographic coverage.
 - A.5.10.4.2 Automatic address validations, distance calculations and trip pricing, if applicable;
 - A.5.10.4.3 Ability to generate a trip manifest (see Section A.5.5 of this Attachment);
 - A.5.10.4.4 Standing Order and Single Trip (as defined in Exhibit A of this Attachment) reservation capability; and
 - A.5.10.4.5 Ability to determine if fixed route transportation is available and appropriate for the member.
- A.5.10.5 The CONTRACTOR's approval and scheduling system shall enable report and data submission as specified in the Agreement.

A.6 PICK-UP AND DELIVERY STANDARDS

- A.6.1 The CONTRACTOR shall ensure that NEMT providers arrive on time for scheduled pick-ups. The NEMT provider may arrive before the scheduled pick-up time, but the member shall not be required to board the vehicle prior to the scheduled pick-up time.
- A.6.2 The CONTRACTOR shall ensure that drivers make their presence known to the member and wait until at least five (5) minutes after the scheduled pick-up time. If the member is not present five (5) minutes after the scheduled pick-up time, the driver shall notify the dispatcher before departing from the pick-up location.
- A.6.3 The CONTRACTOR shall ensure that drivers provide, at a minimum, the approved level of service (curb-to-curb, door-to-door, or hand-to-hand).
- A.6.4 The CONTRACTOR shall ensure that members arrive at pre-arranged times for appointments and are picked up at pre-arranged times for the return leg of the trip. If there is no pre-arranged time for the return leg of the trip, the CONTRACTOR shall ensure that members are picked up within one (1) hour after notification.
- A.6.5 The CONTRACTOR shall ensure that the average waiting time for members for pick-up does not exceed ten (10) minutes past the scheduled pick-up time.
- A.6.6 The CONTRACTOR shall ensure that if the driver will not arrive on time to the pick-up location, the driver shall notify the dispatcher, and the member is contacted.

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- A.6.7 The CONTRACTOR shall ensure that if the driver will not arrive on time to an appointment, the driver shall notify the dispatcher, and the provider is contacted.
- A.6.8 The driver may refuse transportation when the member, his/her escort, or an accompanying adult (for a member under age eighteen (18)), according to a reasonable person's standards, is noticeably indisposed (disorderly conduct, indecent exposure, intoxicated), is armed (firearms), is in possession of illegal drugs, knives and/or other weapons, commits a criminal offense, or is in any other condition that may affect the safety of the driver or persons being transported. The CONTRACTOR shall ensure that if a driver refuses to transport a member the driver immediately notifies the dispatcher, and the dispatcher notifies the CONTRACTOR.
- A.6.9 The CONTRACTOR shall ensure that in the event of an incident or accident (see Section A.17.2 of this Attachment), the driver notifies the dispatcher immediately to report the incident or accident and that, if necessary, alternative transportation is arranged. The CONTRACTOR shall ensure that it is promptly notified of any incident or accident.
- A.6.10 Failure to comply with requirements regarding pick-up and delivery standards may result in liquidated damages as provided in Section 5.20.2 of the Agreement, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

A.7 VEHICLE STANDARDS

- A.7.1 The CONTRACTOR shall ensure that all vehicles meet or exceed applicable federal, state, and local requirements and manufacturer's safety, mechanical, operating, and maintenance standards.
- A.7.2 The CONTRACTOR shall ensure that all vehicles comply with the vehicle requirements developed by the CONTRACTOR and prior approved in writing by TENNCARE, which at a minimum shall include compliance with applicable federal, state, and local requirements, the requirements in this Section, and the requirements in Exhibit C of this Attachment.
- A.7.3 The CONTRACTOR shall ensure that any vehicle used to cross a state's border complies with any and all applicable federal, state (State of Tennessee and/or other state), and local requirements.
- A.7.4 The CONTRACTOR shall ensure that each vehicle has a real-time link, telephone or two-way radio. Pagers are not acceptable as a substitute for this requirement.
- A.7.5 The CONTRACTOR shall ensure that all vehicles transporting members with disabilities comply with applicable requirements of the Americans with Disabilities Act (ADA), including the accessibility specifications for transportation vehicles.
- A.7.6 The CONTRACTOR shall ensure that, at minimum, all vehicles providing stretcher transport are owned and operated by an entity licensed by the Tennessee Department of Health (DOH) to provide invalid services, have an active valid permit issued by DOH as a ground invalid vehicle, and comply with DOH's requirements for ground invalid vehicles.
- A.7.7 The CONTRACTOR shall ensure that, except as otherwise permitted by State of Tennessee law, all ambulances are owned and operated by an entity licensed by DOH to provide ambulance services, have an active valid ambulance permit from DOH, and comply with DOH's requirements for ambulances. The CONTRACTOR shall also ensure that vehicles comply with any applicable local requirements.

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A.7.8 As required in Section A.17 of this Attachment, the CONTRACTOR shall inspect all vehicles (except fixed route, invalid vehicles, and ambulances) for compliance with applicable requirements and shall immediately remove any vehicle that is out of compliance.

A.7.9 Failure to comply with requirements regarding vehicle standards may result in liquidated damages as provided in Section 5.20.2 of the Agreement, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

A.8 TRAINING AND STANDARDS FOR DRIVERS

A.8.1 The CONTRACTOR shall ensure that all drivers receive appropriate training and meet applicable standards, as specified in this Section A.8. These requirements do not apply to drivers of fixed route transportation. Drivers of fixed route transportation shall comply with all rules, regulations, policies and procedures promulgated by the fixed route carrier, federal, state or local law.

A.8.2 Driver Training

A.8.2.1 The CONTRACTOR shall ensure that all drivers receive appropriate training prior to providing services under the Agreement and annually thereafter. This shall include a minimum of thirty-two (32) hours of training prior to providing services under the Agreement and a minimum of fifteen (15) hours of annual training.

A.8.2.2 Driver training shall include, at a minimum the following:

A.8.2.2.1 Customer service;

A.8.2.2.2 Passenger assistance;

A.8.2.2.3 Sensitivity training;

A.8.2.2.4 Mental health and substance abuse issues;

A.8.2.2.5 Title VI requirements (Civil Rights Act of 1964);

A.8.2.2.6 HIPAA privacy requirements;

A.8.2.2.7 ADA requirements;

A.8.2.2.8 Wheelchair securement/safety;

A.8.2.2.9 Seat belt usage and child restraints;

A.8.2.2.10 Handling and reporting accidents and incidents;

A.8.2.2.11 Emergency evacuation;

A.8.2.2.12 Daily vehicle inspection;

A.8.2.2.13 Defensive driving;

A.8.2.2.14 Risk management;

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- A.8.2.2.15 Communications;
- A.8.2.2.16 Infection control;
- A.8.2.2.17 Annual road tests; and
- A.8.2.2.18 Reporting enrollee and provider fraud and abuse.

A.8.3 Standards for Drivers

- A.8.3.1 The CONTRACTOR shall ensure that all drivers comply with driver requirements developed by the CONTRACTOR and prior approved in writing by TENNCARE, which at a minimum shall include compliance with applicable federal, state, and local requirements, the requirements of this Section, and the requirements in Exhibit D of this Attachment.
- A.8.3.2 The CONTRACTOR shall ensure that all drivers are at least eighteen (18) years of age and have a Class D driver license with F (for hire endorsement) or commercial driver license (Class A, B, or C) issued by the State of Tennessee or the equivalent licensure issued by the driver's state of residence.
- A.8.3.3 The CONTRACTOR shall ensure that all drivers meet the State of Tennessee requirements regarding proof of financial responsibility and/or insurance.
- A.8.3.4 The CONTRACTOR shall ensure that any driver that crosses a state's border complies with any and all applicable federal, state (State of Tennessee and/or other state), and local requirements.
- A.8.3.5 The CONTRACTOR shall ensure that any personnel contracted by or employed by a NEMT provider to provide medical assistance to a member during a non-emergency ambulance trip is licensed by the State of Tennessee as an emergency medical technician (EMT) and complies with DOH requirements for EMTs.
- A.8.3.6 The CONTRACTOR shall ensure that all drivers pass a physical examination prior to providing services under the Agreement and have additional physical examinations as necessary to ensure that a driver is qualified to drive a passenger vehicle (e.g., if the driver has a heart attack or stroke). The physical examination shall be at least as extensive as the medical examination required by the United States Department of Transportation's Federal Motor Carrier Safety Administration (FMCSA) for commercial drivers.
- A.8.3.7 The CONTRACTOR shall ensure that all drivers pass a drug test prior to providing services under the Agreement. In addition, the CONTRACTOR shall ensure that an alcohol or drug test is conducted when a trained supervisor/employer of a driver has reasonable suspicion to believe that the driver has violated the CONTRACTOR's policies and procedures regarding use of alcohol and/or controlled substances, that random drug and alcohol tests are conducted, and that post accident drug and alcohol testing is conducted. The CONTRACTOR's policies and procedures for drug and alcohol testing shall, at a minimum, meet the FMCSA's alcohol and drug testing requirements for motor carriers.

- A.8.3.8 The CONTRACTOR shall ensure that criminal background checks pursuant to TCA 38-6-109 as well as national criminal background checks are conducted for all drivers prior to providing services under the Agreement and every five years thereafter. In addition, the CONTRACTOR shall ensure that random national criminal background checks are conducted. The CONTRACTOR shall develop a list of disqualifying criminal offenses, which at a minimum shall include the permanent and interim disqualifying criminal offenses that apply to applicants for a hazardous materials endorsement in Tennessee. Drivers that have been convicted or found not guilty by reason of insanity of any of the disqualifying criminal offenses shall not provide services under the Agreement.
- A.8.3.9 The CONTRACTOR shall ensure that drivers immediately notify the NEMT provider and that the NEMT provider immediately notifies the CONTRACTOR if a driver is arrested for, charged with, or convicted of a criminal offense that would disqualify the driver under the Agreement.
- A.8.3.10 The CONTRACTOR shall ensure that no driver has been convicted of a criminal offense related to the driver's involvement with Medicare, Medicaid, or the federal Title XX services program (see Section 1128 of the Social Security Act and 42 CFR 455.106).
- A.8.3.11 The CONTRACTOR shall verify that drivers are not listed on the Tennessee Sexual Offender Registry or the equivalent registry in the state of the driver's residence prior to providing services under the Agreement and every five (5) years thereafter.
- A.8.3.12 The CONTRACTOR shall ensure that drivers pass a national driver license background check prior to providing services under the Agreement. This initial national driver license background check shall, at a minimum, show the following:
 - A.8.3.12.1 No conviction within the past ten (10) years for a major moving traffic violation such as driving while intoxicated or driving under the influence;
 - A.8.3.12.2 No conviction for reckless driving within the previous thirty-six (36) month period;
 - A.8.3.12.3 No conviction for leaving the scene of a personal injury or fatal accident within the previous thirty-six (36) months;
 - A.8.3.12.4 No conviction for a felony involving the use of an automobile within the previous thirty-six (36) months;
 - A.8.3.12.5 Conviction for no more than two (2) minor moving traffic violations such as speeding, failure to stop, or improper operation of a motor vehicle within the previous thirty-six (36) months;
 - A.8.3.12.6 Conviction for no more than one (1) at-fault accident resulting in personal injury or property damage within the previous thirty-six (36) months; and
 - A.8.3.12.7 Not have a combination of conviction for one (1) at-fault accident resulting in personal injury or property damage and conviction for one (1) unrelated minor moving traffic violation within the previous thirty-six (36) months.

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- A.8.3.13 The CONTRACTOR shall ensure that drivers pass an annual national driver license background check. The annual check shall, at a minimum, show the following:
 - A.8.3.13.1 No conviction for a major moving traffic violation such as driving while intoxicated, driving under the influence, or reckless driving;
 - A.8.3.13.2 No conviction for leaving the scene of a personal injury or fatal accident;
 - A.8.3.13.3 No conviction for a felony involving the use of an automobile;
 - A.8.3.13.4 No more than two (2) convictions for minor moving traffic violations such as speeding, failure to stop, or improper operation of a motor vehicle;
 - A.8.3.13.5 No more than one (1) conviction for an at-fault accident resulting in personal injury or property damage; and
 - A.8.3.13.6 Not have a combination of one (1) conviction for an at-fault accident resulting in personal injury or property damage and one (1) conviction for an unrelated minor moving traffic violation.
 - A.8.3.14 The CONTRACTOR shall require that drivers immediately notify the NEMT provider and that the NEMT provider immediately notifies the CONTRACTOR of any moving traffic violation or if a driver's license is suspended or revoked.
 - A.8.3.15 The CONTRACTOR shall ensure that all ambulance drivers and invalid vehicle drivers comply with applicable DOH and local requirements.
 - A.8.3.16 The CONTRACTOR shall require that drivers maintain daily transportation logs containing, at a minimum, the information listed in Exhibit E of this Attachment.
 - A.8.3.17 As required in Section A.17 of this Attachment, the CONTRACTOR shall monitor drivers and immediately remove any driver that is out of compliance with applicable requirements.
- A.8.4 Failure to comply with requirements regarding driver training and driver standards may result in liquidated damages as provided in Section 5.20.2 of the Agreement, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

A.9 NEMT CALL CENTER

- A.9.1 The CONTRACTOR shall maintain a NEMT Call Center to handle requests for NEMT services as well as questions, comments, and inquiries from members and their representatives, NEMT providers, and providers regarding NEMT services. The NEMT Call Center may use the same infrastructure as the CONTRACTOR's member services line, but the CONTRACTOR shall have a separate line or queue for NEMT calls, and NEMT Call Center staff shall be dedicated to NEMT calls.
- A.9.2 The NEMT Call Center shall be appropriately staffed twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty-five (365) days a year to handle the call volume in compliance with the performance standards in Section A.9.6 of this Attachment. The CONTRACTOR shall ensure continuous availability of NEMT Call Center services.

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- A.9.3 Between the hours of 7:00 PM and 5:00 AM in the time zone applicable to the Grand Region served by the CONTRACTOR (for Middle, the applicable time zone shall be Central Time), the CONTRACTOR may use alternative arrangements to handle NEMT calls so long as there is no additional burden on the caller (e.g., the caller is not required to call a different number or to make a second call), and the call is promptly returned by the CONTRACTOR.
- A.9.4 For hours that the CONTRACTOR is using alternative arrangements to handle NEMT calls (see Section A.9.3 of this Attachment), the CONTRACTOR shall provide an after hours message in, at a minimum, English and Spanish instructing the caller how to access the alternative arrangement (not requiring a second call) and also offering the caller the opportunity to leave a message.
- A.9.5 The CONTRACTOR's NEMT Call Center system shall have the capability to identify and record the phone number of the caller if the caller's phone number is not blocked.
- A.9.6 The CONTRACTOR shall have the capability of making outbound calls.
- A.9.7 The CONTRACTOR shall maintain sufficient equipment and NEMT Call Center staff to handle anticipated call volume and ensure that calls are received and processed in accordance with the requirements of this Section A.9 and the following performance standards for each line or queue:
 - A.9.7.1 Blocked calls – No more than one percent (1%) of calls are blocked;
 - A.9.7.2 Answer rate – At least ninety percent (90%) of all calls are answered by a live voice within thirty (30) seconds;
 - A.9.7.3 Abandoned calls – No more than five percent (5%) of calls are abandoned; and
 - A.9.7.4 Hold time – Average hold time, including transfers to other CONTRACTOR staff, is no more than three (3) minutes.
- A.9.8 If a NEMT call cannot be answered by a live voice within thirty (30) seconds, the CONTRACTOR shall provide a message in, at a minimum, English and Spanish advising the caller that the call will not be answered promptly and offering the caller the opportunity to leave a message. If the message requests the CONTRACTOR to return the call, the CONTRACTOR shall promptly return the call.
- A.9.9 The CONTRACTOR shall have qualified bi-lingual (English and, at minimum, Spanish) NEMT Call Center staff to communicate with callers who, at a minimum, speak Spanish. The CONTRACTOR shall provide oral interpretation services via a telephone interpretation service free of charge to callers with Limited English Proficiency.
- A.9.10 The CONTRACTOR's NEMT Call Center shall accommodate callers who are hearing and/or speech impaired.
- A.9.11 The CONTRACTOR shall operate an automatic call distribution system for its NEMT Call Center.
- A.9.12 The CONTRACTOR shall route incoming calls to the NEMT Call Center to, at minimum, an English-speaking member queue, a Spanish-speaking member queue, a NEMT provider queue, and a provider queue.

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- A.9.13 The welcome message for the NEMT Call Center shall be in English and shall include, at minimum, a Spanish language prompt.
- A.9.14 The CONTRACTOR shall develop NEMT Call Center scripts for calls requesting NEMT services that include a sequence of questions and criteria that the NEMT Call Center representatives shall use to determine the member's eligibility for NEMT services, the appropriate mode of transportation, the purpose of the trip and all other pertinent information relating to the trip (see Section A.4 of this Attachment). The CONTRACTOR may develop additional scripts for other types of NEMT calls from members, providers, and NEMT providers. Any script for use with an enrollee shall be written at the sixth (6th) grade reading level and must be prior approved in writing by TENNCARE.
- A.9.15 The CONTRACTOR shall advise callers that calls to the NEMT Call Center are monitored and recorded for quality assurance purposes.
- A.9.16 The CONTRACTOR shall record a statistically valid sample of incoming and outgoing calls to/from the NEMT Call Center for quality control, program integrity and training purposes.
- A.9.17 The CONTRACTOR shall monitor and audit at least one percent (1%) of calls of each NEMT Call Center staff member on a monthly basis. The CONTRACTOR shall develop a tool for auditing calls, which shall include components to be audited and the scoring methodology. The CONTRACTOR shall use this monitoring to identify problems or issues, for quality control, and for training purposes. The CONTRACTOR shall document and retain results of this monitoring and subsequent training.
- A.9.18 The CONTRACTOR's NEMT Call Center system shall be able to produce the reports specified in Section A.19 of this Attachment as well as on request and ad hoc reports that TENNCARE may request.
- A.9.19 The CONTRACTOR shall analyze data collected from its NEMT Call Center system as necessary to perform quality improvement, fulfill the reporting and monitoring requirements of the Agreement, and ensure adequate resources and staffing.
- A.9.20 Failure to comply with requirements regarding the NEMT Call Center may result in liquidated damages as provided in Section 5.20.2 of the Agreement, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

A.10 NEMT MEMBER EDUCATION

- A.10.1 The CONTRACTOR shall develop materials to inform and educate members about NEMT services.
- A.10.2 The materials shall include, but not be limited to, information regarding eligibility for NEMT services, what services are covered/not covered, and how to request NEMT services, including the number to call, applicable timeframes, the approval and scheduling process, the use of fixed route, and Standing Orders.
- A.10.3 All written materials shall comply with Section 2.17 of the Agreement and must be prior approved in writing by TENNCARE.

A.10.4 Prior to the date of implementation, as specified by TENNCARE, the CONTRACTOR shall mail member education materials to its members by first class mail and at the CONTRACTOR's expense.

A.11 NON-COMPLIANT MEMBERS

A.11.1 The CONTRACTOR shall provide targeted education to members who do not comply with the CONTRACTOR's policies and procedures regarding NEMT services. All member materials shall comply with Section 2.17 of the Agreement and must be prior approved in writing by TENNCARE.

A.11.2 The CONTRACTOR shall not take any action to sanction members who do not comply with the CONTRACTOR's policies and procedures.

A.11.3 Members shall not be charged for no-shows (as defined in Exhibit A of this Attachment).

A.12 NEMT PROVIDER NETWORK

A.12.1 The CONTRACTOR shall establish a network of qualified NEMT providers to provide covered NEMT services to meet the transportation needs of members. In developing its network of qualified NEMT providers the CONTRACTOR shall comply with Section 2.11.1 of the Agreement.

A.12.2 The CONTRACTOR shall have sufficient NEMT providers in its network (numbers and types of vehicles and drivers) so that the failure of any NEMT provider to perform will not impede the ability of the CONTRACTOR to provide NEMT services in accordance with the requirements of the Agreement.

A.12.3 The CONTRACTOR shall ensure that its NEMT providers have a sufficient number of vehicles and drivers available to meet the timeliness requirements of the Agreement (see Section A.5 of this Attachment).

A.12.4 The CONTRACTOR shall provide Human Resource Agencies (HRAs) the opportunity to become a NEMT provider if the HRA is qualified to provide the service and agrees to the terms of the CONTRACTOR's NEMT provider agreement, which shall be no more restrictive than for other NEMT providers and include alternative indemnification language as specified in Section A.13.4 of this Attachment.

A.12.5 The CONTRACTOR shall provide Division of Intellectual Disabilities Services (DIDS) residential and day service waiver providers the opportunity to become a NEMT provider if the provider is qualified to provide the service and agrees to the terms of the CONTRACTOR's NEMT provider agreement, which shall be no more restrictive than for other NEMT providers. These providers shall only provide covered NEMT services to members receiving HCBS MR waiver services from the provider. The CONTRACTOR shall reimburse these providers for covered NEMT to TennCare covered services (see definition in Exhibit A) and shall not reimburse these providers for NEMT to services provided through a HCBS MR waiver. The CONTRACTOR shall reimburse these providers in accordance with rates paid to other NEMT providers for the provision of NEMT services.

A.12.6 The CONTRACTOR shall ensure that its NEMT providers are qualified to perform their duties. This includes, but is not limited to, meeting applicable federal, state or local licensure,

certification, or registration requirements. Failure to comply with requirements regarding licensure requirements may result in liquidated damages as provided in Section 5.20.2 of the Agreement.

A.12.7 The CONTRACTOR's NEMT provider network must be prior approved in writing by TENNCARE and shall be subject to ongoing review and approval by TENNCARE. Failure to comply with NEMT provider network requirements may result in liquidated damages as provided in Section 5.20.2 of the Agreement.

A.13 NEMT PROVIDER AGREEMENTS

A.13.1 All NEMT provider agreements shall comply with applicable requirements of the Agreement, including but not limited to prior written approval of template agreements and revisions thereto by the Tennessee Department of Commerce and Insurance (TDCI).

A.13.2 Except for fixed route, NEMT providers used for contingency or back-up (see Section A.5.9 of this Attachment), or as otherwise agreed to by TENNCARE in writing, the CONTRACTOR shall not use transportation providers with which the CONTRACTOR has not executed a provider agreement.

A.13.3 In addition to the requirements in other sections of the Agreement, all NEMT provider agreements shall meet the following minimum requirements:

A.13.3.1 Include provisions related to payment for cancellations (see Section A.5.5.5 of this Attachment), no-shows (as defined in Exhibit A to this Attachment), escorts, and adults accompanying members under age eighteen (18);

A.13.3.2 Specify the services to be provided by the NEMT provider, including, as applicable, mode(s) of transportation and dispatching.

A.13.3.3 Include expectations for door-to-door, hand-to-hand, and curb-to-curb service (see Section A.4.4 of this Attachment and definitions in Exhibit A of this Attachment);

A.13.3.4 Include or reference trip manifest requirements (see Section A.5.5 of this Attachment);

A.13.3.5 Include urgent trip requirements (see Section A.5.7 of this Attachment);

A.13.3.6 Include or reference back-up service requirements (see Section A.5.9 of this Attachment);

A.13.3.7 Include or reference pick-up and delivery standards (see Section A.6 of this Attachment);

A.13.3.8 Require the NEMT provider to notify the CONTRACTOR of specified events, including no-shows (see Section A.6.2 of this Attachment), accidents, moving traffic violations, and incidents (see Section A.6.9 of this Attachment);

A.13.3.9 Include or reference vehicle standards (see Section A.7 of this Attachment);

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- A.13.3.10 Require the NEMT provider to notify the CONTRACTOR if a vehicle is out of service or otherwise unavailable;
- A.13.3.11 Include or reference training requirements for the NEMT provider (see Section A.16.2 of this Attachment) and for drivers (see Section A.8.2 of this Attachment);
- A.13.3.12 Include or reference driver standards (see Section A.8.3), including driver log requirements (see Section A.8.3.16 of this Attachment) and require the NEMT provider to provide copies of driver logs to the CONTRACTOR upon request; and
- A.13.3.13 Require the NEMT provider to secure and maintain adequate insurance coverage prior to providing any NEMT services under the Agreement, including, at minimum, the following:
 - A.13.3.13.1 Workers' Compensation/ Employers' Liability (including all states coverage) with a limit not less than the relevant statutory amount or one million dollars (\$1,000,000) per occurrence for employers' liability whichever is greater;
 - A.13.3.13.2 Comprehensive Commercial General Liability (including personal injury and property damage, premises/operations, independent contractor, contractual liability and completed operations/products) with a bodily injury/property damage combined single limit not less than one million dollars (\$1,000,000) per occurrence and two million dollars (\$2,000,000) in the aggregate; and
 - A.13.3.13.3 Automobile Coverage (including owned, leased, hired, and non-owned vehicles) with a bodily injury/property damage combined single limit not less than one million dollars (\$1,000,000) per occurrence.
- A.13.4 If the CONTRACTOR has a provider agreement with a HRA, the agreement shall meet the requirements specified in Sections A.13.1 and A.13.3 above and shall also include indemnification language negotiated with the HRA and prior approved in writing by TENNCARE as an alternative to the indemnification language referenced in the Agreement.
- A.13.5 Failure to comply with provider agreement requirements may result in liquidated damages as provided in Section 5.20.2 of the Agreement.

A.14 PAYMENT FOR NEMT SERVICES

A.14.1 General

In addition to requirements in the Agreement regarding payment for services, when paying for NEMT services the CONTRACTOR shall comply with the requirements in this Attachment.

A.14.2 Payment for Fixed Route

- A.14.2.1 The CONTRACTOR shall make every effort to provide tickets/tokens/passes to a member in a manner that ensures receipt prior to the scheduled transportation.
- A.14.2.2 If the CONTRACTOR cannot provide tickets/token/passes prior to the scheduled transportation, the CONTRACTOR shall offer the member the choice of having the CONTRACTOR arrange alternate transportation or reimbursing the member for the

cost of the applicable fare for the fixed route transportation approved by the CONTRACTOR.

- A.14.2.3 The CONTRACTOR may negotiate agreements with fixed route transportation entities. Such agreements must be prior approved in writing by TENNCARE.

A.14.3 Validation Checks

A.14.3.1 The CONTRACTOR shall have policies and procedures for conducting random post-transportation validation checks. These policies and procedures must be prior approved in writing by TENNCARE. These policies and procedures shall specify how the CONTRACTOR will conduct post-transportation validation checks (e.g., by calling providers or matching NEMT claims and physical health/behavioral health claims), the frequency of the checks (e.g., one point five percent (1.5%) of NEMT claims received in a month), and any follow-up activities (e.g., if the CONTRACTOR determines that transportation for a particular member was not to a TennCare covered service, the CONTRACTOR validates the next three (3) requests for that member before a trip is approved (see Section A.4.6 of this Attachment)). If the CONTRACTOR suspects fraud or abuse, it shall comply with the fraud and abuse requirements of the Agreement.

A.14.3.2 The CONTRACTOR shall perform post-transportation validation checks for fixed route transportation as specified in the CONTRACTOR's policies and procedures, which must be prior approved in writing by TENNCARE.

A.15 NEMT CLAIMS MANAGEMENT

A.15.1 The CONTRACTOR shall process NEMT provider claims consistent with the claims management requirements of the Agreement.

A.15.2 The CONTRACTOR shall submit encounter data for NEMT services that meets the requirements in the Agreement, including compliance with HIPAA's electronic transactions and code set requirements.

A.15.3 The CONTRACTOR shall ensure that ninety percent (90%) of clean claims for payment for NEMT services delivered to a member are processed within thirty (30) calendar days of the receipt of such claims.

A.15.4 The CONTRACTOR shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all NEMT provider claims for covered NEMT services delivered to a member.

A.15.5 The CONTRACTOR shall pay ninety-seven percent (97%) of NEMT claims accurately upon initial submission.

A.15.6 The CONTRACTOR shall conduct an audit of NEMT claims that complies with the requirements in the Agreement regarding a claims payment accuracy audit.

A.15.7 Failure to comply with requirements regarding NEMT claims management may result in liquidated damages as provided in Section 5.20.2 of the Agreement, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

A.16 NEMT PROVIDER MANUAL AND NEMT PROVIDER EDUCATION AND TRAINING

A.16.1 NEMT Provider Manual

- A.16.1.1 The CONTRACTOR shall issue a NEMT provider manual to all NEMT providers. The CONTRACTOR may distribute the NEMT provider manual electronically (e.g., through its website) so long as NEMT providers are notified about how to obtain the electronic copy and how to request a hard copy at no charge to the NEMT provider.
- A.16.1.2 The NEMT provider manual must be prior approved in writing by TENNCARE and shall include, at a minimum, the following:
 - A.16.1.2.1 Description of the TennCare program;
 - A.16.1.2.2 Covered and non-covered NEMT services, including requirement that transportation must be to a TennCare covered service;
 - A.16.1.2.3 Prior approval requirements;
 - A.16.1.2.4 Vehicle requirements;
 - A.16.1.2.5 Driver requirements;
 - A.16.1.2.6 Protocol for encounter data elements reporting/records;
 - A.16.1.2.7 Claims submission protocols and standards, including instructions and all information necessary for a clean claim;
 - A.16.1.2.8 Payment policies;
 - A.16.1.2.9 Information on members' appeal rights;
 - A.16.1.2.10 Member rights and responsibilities;
 - A.16.1.2.11 Policies and procedures of the provider complaint system; and
 - A.16.1.2.12 Important phone numbers of all departments/staff a NEMT provider may need to reach at the CONTRACTOR's MCO.
- A.16.1.3 The CONTRACTOR shall disseminate bulletins to NEMT providers as needed to incorporate any needed changes to the provider manual.

A.16.2 NEMT Provider Education and Training

- A.16.2.1 The CONTRACTOR shall develop and implement a plan to educate NEMT providers, including initial orientation sessions and continuing education. The initial orientation shall include at minimum the topics included in the NEMT provider manual.
- A.16.2.2 The CONTRACTOR shall ensure that all NEMT provider staff, including but not limited to dispatchers, supervisors, and mechanics, receive appropriate training before providing services under the Agreement and on an ongoing basis thereafter.

A.17 NEMT QUALITY ASSURANCE AND MONITORING

A.17.1 NEMT Quality Assurance Program

- A.17.1.1 As part of the CONTRACTOR's QM/QI program required by the Agreement, the CONTRACTOR shall develop and implement a quality assurance program for NEMT services. The description of the program (the NEMT Quality Assurance Plan)

shall include policies and procedures outlining the objectives and scope of the program as well as activities for ongoing monitoring, evaluation and improvement of the quality and appropriateness of NEMT services.

A.17.1.2 The NEMT Quality Assurance Plan shall include at least the following:

A.17.1.2.1 The CONTRACTOR's procedures for monitoring and improving member satisfaction with NEMT services;

A.17.1.2.2 The CONTRACTOR's procedures for ensuring that all NEMT services paid for are properly approved and actually rendered, including but not limited to validation checks (see Sections A.4.6 and A.14.3) and an annual analysis matching physical health and behavioral health claims/encounters and NEMT claims/encounters;

A.17.1.2.3 The CONTRACTOR's procedures for monitoring and improving the quality of transportation provided pursuant to the Agreement, including transportation provided by fixed route; and

A.17.1.2.4 The CONTRACTOR's monitoring plan for NEMT providers, as detailed in Section A.17.3 of this Attachment.

A.17.2 Accidents and Incidents

The CONTRACTOR shall document accidents and incidents that occur while services are being delivered under the Agreement. An incident is defined as an occurrence, event, breakdown, or public disturbance that interrupts the trip, causing the driver to stop the vehicle, such as a passenger being unruly or ill.

A.17.3 NEMT Provider Monitoring Plan

A.17.3.1 The CONTRACTOR shall develop and implement a plan for monitoring NEMT providers' compliance with all applicable local, state and federal law. The plan shall also monitor NEMT providers' compliance with the terms of their provider agreements and all NEMT provider-related requirements of the Agreement, including but not limited to driver requirements, vehicle requirements, member complaint resolution requirements, and the delivery of courteous, safe, timely and efficient transportation services.

A.17.3.2 Monitoring activities shall include, but are not limited to:

A.17.3.2.1 On-street observations;

A.17.3.2.2 Random audits of NEMT providers;

A.17.3.2.3 Accident and incident reporting;

A.17.3.2.4 Statistical reporting of trips;

A.17.3.2.5 Analysis of complaints;

A.17.3.2.6 Driver licensure, driving record, experience and training;

A.17.3.2.7 Enrollee safety;

A.17.3.2.8 Enrollee assistance;

A.17.3.2.9 Completion of driver trip logs;

A.17.3.2.10 Driver communication with dispatcher; and

A.17.3.2.11 Routine scheduled vehicle inspections and maintenance.

A.17.4 NEMT Provider Corrective Action

A.17.4.1 The CONTRACTOR shall have policies and procedures for ensuring that an appropriate corrective action is taken when a NEMT provider furnishes inappropriate or substandard services, when a NEMT provider does not furnish services that should have been furnished, or when a NEMT provider is out of compliance with federal, state, or local law.

A.17.4.2 The CONTRACTOR shall immediately remove from service any vehicle, driver, or EMT found to be out of compliance with the requirements of the Agreement, including any federal, state or local law. The vehicle, driver, or EMT may be returned to service only after the CONTRACTOR verifies that the deficiencies have been corrected. Any deficiencies, and actions taken to remedy deficiencies, shall be documented and become a part of the vehicle's and/or the person's permanent records.

A.17.4.3 As required in Section A.19.6.7 of this Attachment, the CONTRACTOR shall report on monitoring activities, monitoring findings, corrective actions taken, and improvements made.

A.17.5 NEMT Member Satisfaction Survey

A.17.5.1 The CONTRACTOR shall conduct a member satisfaction survey regarding NEMT services for the first six (6) months after implementation of the requirements in this Attachment or as otherwise specified by TENNCARE and annually thereafter.

A.17.5.2 The purpose of the survey is to verify the availability, appropriateness and timeliness of the trips provided and the manner in which the CONTRACTOR's staff and the NEMT provider's staff interacted with members.

A.17.5.3 The survey topics shall include, but are not limited to:

A.17.5.3.1 NEMT Call Center interaction;

A.17.5.3.2 Confirmation of a scheduled trip;

A.17.5.3.3 Driver and CONTRACTOR staff courtesy;

A.17.5.3.4 Driver assistance, when required;

A.17.5.3.5 Overall driver behavior;

A.17.5.3.6 Driver safety and operation of the vehicle;

A.17.5.3.7 Condition, comfort and convenience of the vehicle; and

A.17.5.3.8 Punctuality of service.

A.17.5.4 The format, sampling strategies and questions of the survey must be prior approved in writing by TENNCARE, and TENNCARE may specify questions that are to appear in the survey.

A.17.5.5 The CONTRACTOR shall submit reports regarding these surveys as required in Section A.19.6.8 of this Attachment.

A.17.6 Vehicle Inspection

A.17.6.1 The CONTRACTOR shall conduct a comprehensive inspection of all NEMT providers' vehicles prior to the implementation of NEMT requirements in this Attachment. Thereafter, the CONTRACTOR shall conduct a comprehensive inspection of all vehicles at least annually. The CONTRACTOR is not required to inspect fixed route vehicles, invalid vehicles, ambulances, or vehicles for NEMT providers with which the CONTRACTOR does not have a provider agreement (see Section A.13.2 of this Attachment).

A.17.6.2 The CONTRACTOR shall develop and implement policies and procedures for vehicle inspections. These policies and procedures must be prior approved in writing by TENNCARE and shall include inspection forms, inspection stickers and a list of trained inspectors, including the names of all employees or subcontractors who are authorized to inspect vehicles for the CONTRACTOR. Inspection forms shall have a checklist that includes all the applicable vehicle standards of the Agreement and of local, state and federal law. The CONTRACTOR shall test all communication equipment during all vehicle inspections.

A.17.6.3 Upon completion of a successful inspection, an inspection sticker shall be applied to the vehicle. The inspection sticker shall be placed on the outside of the passenger side rear window in the lower right corner. The sticker shall state the license plate number and vehicle identification number of the vehicle. Records of all inspections shall be maintained by the CONTRACTOR.

A.18 NEMT SUBCONTRACTS

If the CONTRACTOR delegates any of its responsibilities regarding NEMT services, it shall comply with the subcontracting requirements in the Agreement, including prior written approval of the subcontract by TENNCARE.

A.19 NEMT REPORTING

A.19.1 NEMT Status Reports

A.19.1.1 During the initial six (6) months after implementation of NEMT services pursuant to this Attachment, and longer if requested by TENNCARE, the CONTRACTOR shall submit a weekly status report. This report shall include, but not be limited to, a NEMT narrative summary of accomplishments, identification of open and closed

issues, key Call Center telephone statistics (e.g., number of calls received, number/percentage of calls placed on hold, average hold time, number/percentage of abandoned calls; average talk time; and number of staff to answer calls by time of day/day of week), key statistics on requests for transportation (e.g., number of requests by mode of transportation, number denied and approved, and mode of transportation approved); and key statistics on pick-up and delivery standards.

- A.19.1.2 The CONTRACTOR shall submit a monthly status report. This report shall include, but not be limited to, summary and detail information on accomplishments, outstanding issues, NEMT Call Center statistics, NEMT Call Center activities, and statistics regarding pick-up and delivery standards.

A.19.2 Approval and Utilization Reports

- A.19.2.1 Approval Report. The CONTRACTOR shall submit a quarterly approval report that includes both summary and detail information on transportation requested, approved, modified and denied, including the modification and denial reason. The report shall provide this information by mode of transportation and category of service.
- A.19.2.2 Approval and Scheduling Timeframes Report. The CONTRACTOR shall submit a quarterly report that provides information on timeframes for approving/denying and scheduling transportation.
- A.19.2.3 Pick-up and Delivery Standards Report. The CONTRACTOR shall submit a monthly report that documents the number and percentage of pick-ups that were missed by a NEMT provider, pick-ups or drop-offs that were late, and drop-offs where the member missed an appointment and provides the average amount of time that the pick-ups or drop-offs were late. This information shall be provided by mode of transportation and by county.
- A.19.2.4 Utilization Report. The CONTRACTOR shall submit a monthly utilization that provides both summary and detail information on NEMT services provided to members. The report shall include, at minimum, by mode of transportation and category of service: the number of trips, number of unduplicated members, and number of miles.

A.19.3 NEMT Call Center Reports

- A.19.3.1 The CONTRACTOR shall submit a monthly report that provides summary and detail statistics on the NEMT Call Center telephone lines/queues and includes identification of potential issues, trends, and any corrective action taken.
- A.19.3.2 The CONTRACTOR shall submit a monthly report that summarizes the results of the CONTRACTOR's call monitoring and any corrective action taken.

A.19.4 NEMT Provider Enrollment File

The CONTRACTOR's monthly provider enrollment file shall include NEMT providers. In addition, the CONTRACTOR shall provide the following information to TENNCARE:

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A.19.4.1 Driver Roster. The CONTRACTOR shall provide a driver roster for each NEMT provider that includes, at minimum: the driver's name, license number, and social security number.

A.19.4.2 Vehicle Listing. The CONTRACTOR shall provide a vehicle listing for each NEMT provider that includes, at minimum: the type of vehicle and the vehicle's manufacturer, model, model year, and vehicle identification number.

A.19.5 NEMT Claims Management Reports

A.19.5.1 The CONTRACTOR shall submit a quarterly NEMT prompt payment report. The report shall include the number and percentage of clean NEMT claims that are processed within thirty (30) calendar days of receipt, the number and percentage of NEMT claims that are processed within sixty (60) calendar days of receipt, the number and percentage of NEMT claims and the dollar value and percentage of dollars associated with claims that are processed within the timeframes specified by TENNCARE (e.g., fifteen (15) days, thirty (30) days, etc.), and the average time (number of days) that it takes to process NEMT claims.

A.19.5.2 The CONTRACTOR shall submit a quarterly NEMT claims payment accuracy report. The report shall be based on an audit conducted by the CONTRACTOR in accordance with Section 2.22.6 of the Agreement using a random sample of all "processed or paid" NEMT claims. The report shall include the number and percentage of NEMT claims that are paid accurately for each month in the quarter.

A.19.6 NEMT Quality Assurance and Monitoring Reports

A.19.6.1 Member NEMT Complaint Report. The CONTRACTOR shall submit a quarterly member complaints report (see Section 1 of the Agreement for the definition of complaint, which includes both written and verbal statements) that summarizes the number of complaints regarding NEMT by type, analyzes the information, particularly noting patterns or trends, and describes any corrective action taken to ensure quality of services.

A.19.6.2 NEMT Provider Complaint Report. The CONTRACTOR shall submit a quarterly NEMT provider complaints report that summarizes the number of verbal and written complaints by type, analyzes the information, including patterns or trends, and describes any corrective action.

A.19.6.3 NEMT Quality Assurance Plan. As part of its annual QM/QI reporting required by the Agreement, the CONTRACTOR shall submit an annual NEMT quality assurance plan (see Section A.17.1 of this Attachment).

A.19.6.4 NEMT Validation Checks.

A.19.6.4.1 The CONTRACTOR shall submit a quarterly report summarizing the pre-transportation validation checks (see Section A.4.6 of this Attachment) conducted by the CONTRACTOR, the findings, and any corrective actions.

- A.19.6.4.2 The CONTRACTOR shall submit a quarterly report summarizing the post-transportation validation checks (see Section A.14.3 of this Attachment) conducted by the CONTRACTOR, the findings, and any corrective actions.
- A.19.6.5 Post-Payment Review Report. The CONTRACTOR shall submit an annual report summarizing the methods and findings for the post-payment review (see Section A.17.1.2.2 of this Attachment) and identifying opportunities for improvement.
- A.19.6.6 Accidents and Incidents.
 - A.19.6.6.1 Immediately upon becoming aware of any accident resulting in driver or passenger injury or fatality that occurs while providing services under the Agreement, the CONTRACTOR shall notify TENNCARE. The CONTRACTOR shall submit a written accident report within five (5) business days of the accident and shall cooperate in any related investigation. A police report shall be included in the accident report or provided as soon as possible.
 - A.19.6.6.2 The CONTRACTOR shall submit a quarterly report of all accidents, moving traffic violations, and incidents.
- A.19.6.7 Monitoring Plan.
 - A.19.6.7.1 The CONTRACTOR shall submit an annual NEMT provider monitoring plan (see Section A.17.3 of this Attachment).
 - A.19.6.7.2 The CONTRACTOR shall submit an annual report summarizing its monitoring activities, the findings, corrective actions, and improvements for NEMT services provided under the Agreement.
- A.19.6.8 Satisfaction Survey Report. The CONTRACTOR shall submit a report (three months after the initial survey period and then annually) summarizing the member survey methods and findings and identifying opportunities for improvement.

A.20 PERFORMANCE STANDARDS

The CONTRACTOR agrees that TENNCARE may assess liquidated damages against the CONTRACTOR for failure to meet the performance standards as specified in Exhibit F of this Attachment.

Exhibit A
DEFINITIONS, ACRONYMS, AND ABBREVIATIONS

The terms used in this Attachment shall be given the meaning used in TennCare rules and regulations. However, the following terms, when used in this Attachment, shall be construed and/or interpreted as follows, unless the context expressly requires a different construction and/or interpretation.

Definitions

1. **Commercial Carrier Transport:** Transportation provided by a common carrier, including but not limited to buses (e.g., Greyhound), trains (e.g., Amtrak), airplanes, and ferries.
2. **Curb-to-Curb Service:** Transportation provided to passengers who need little if any assistance between the vehicle and the door of the pick-up point or destination. The driver shall provide assistance according to the enrollee's needs, including assistance as necessary to enter and exit the vehicle, but assistance shall not include the lifting of any enrollee. The driver shall remain at or near the vehicle and not enter any buildings.
3. **Door-to-Door Service:** Transportation provided to enrollees with disabilities who need assistance to safely move between the door of the vehicle and the door of the passenger's pick-up point or destination. The driver shall exit the vehicle and assist the enrollee from the door of the pick-up point, e.g., residence, accompany the passenger to the door of the vehicle, and assist the passenger in entering the vehicle. The driver shall assist the enrollee throughout the transport and to the door of the destination.
4. **Federal Motor Carrier Safety Administration (FMCSA):** A separate administration within the United States Department of Transportation established pursuant to the Motor Carrier Safety Improvement Act of 1999. Its primary mission is to reduce crashes, injuries, and fatalities involving large trucks and buses.
5. **Fixed Route:** Transportation by means of a public transit vehicle that follows an advertised route on an advertised schedule, does not deviate from the route or the schedule, and picks up passengers at designated stops. Fixed route transportation includes, but is not limited to, non-commercial buses, commuter trains, and trolleys.
6. **Hand-to-Hand Service:** Transportation of an enrollee with disabilities from an individual at the pick-up point to a provider staff member, family member or other responsible party at the destination.
7. **Hospital Discharge:** Notification by a hospital that an enrollee is ready for discharge. A hospital discharge shall be considered an urgent trip.
8. **HRAs:** Human Resource Agencies. These agencies are the delivery system for human services, including transportation to rural residents, throughout the State of Tennessee. The nine HRAs are: Delta HRA, East Tennessee HRA, First Tennessee HRA, Mid-Cumberland HRA, Northwest HRA, South Central Development District, South West HRA, Upper Cumberland HRA, and South East HRA.
9. **No- Show:** A trip is considered a no-show when the driver arrived on time, made his/her presence known, and the member is not present five (5) minutes after the scheduled pick-up time.

10. **Private Automobile:** An enrollee's personal vehicle or the personal vehicle of a family member or friend, to which the enrollee has access. Private automobile is not a covered NEMT service.
11. **Single Trip:** Transport to and/or from a single TennCare covered service. A trip generally has at least two (2) trip legs but there can be one (1) or more than two (2) (multiple) trip legs.
12. **Standing Order:** Transport to and/or from multiple recurring medical appointments for TennCare covered services for the same enrollee with the same provider for the same treatment or condition (can be one (1) or multiple trip legs).
13. **TennCare Covered Services:** The health care services available to TennCare enrollees, as defined in TennCare rules and regulations. This includes, but is not limited to, physical health, behavioral health, pharmacy, dental services and institutional services. TennCare covered services includes TENNderCare services. For purposes of NEMT, TennCare covered services does not include alternatives to institutional services (HCBS or 1915(c) waiver services).
14. **Tennessee Division of Intellectual Disabilities Services (DIDS):** The state agency responsible for providing services and supports to Tennesseans with intellectual disabilities. DIDS is a division of the Tennessee Department of Finance and Administration.
15. **Trip Leg:** One-way transport from a pick-up point to a destination. A trip generally has at least two (2) trip legs.
16. **Urgent Trip:** Covered NEMT services required for an unscheduled episodic situation in which there is no immediate threat to life or limb but the enrollee must be seen on the day of the request (can be one (1) or multiple trip legs). A hospital discharge shall be an urgent trip.

Exhibit B
TRIP MANIFESTS

The trip manifests supplied to NEMT providers shall include all necessary information for the driver to perform the trip for each enrollee, including but not limited to:

1. Number assigned by the CONTRACTOR for approved trip;
2. NEMT provider name;
3. The mode of transportation;
4. MCO name;
5. Enrollee's name;
6. Enrollee's age;
7. Enrollee's sex;
8. Trip date;
9. Number of legs for the trip (e.g., one-way, round trip, or multiple legs);
10. Origin of trip/place of pick-up (e.g., residence)
11. Time of pick-up for the time zone applicable to the pick-up location;
12. Address of the pick-up, including street address, city, county, state, and zip code;
13. Enrollee's phone number(s);
14. Number of riders;
15. Time of appointment for the time zone applicable to the appointment location;
16. Provider name;
17. Address of the provider, including street address, city, county, state, and zip code;
18. Provider's phone number(s);
19. Return trip times for the applicable time zone(s) and addresses, if applicable;
20. Any additional stops (e.g., pharmacy);
21. Any special needs of the enrollee;
22. Any special instructions to the driver, e.g., door-to-door or hand-to-hand service;
23. Whether enrollee has third party coverage, including Medicare; and
24. Notes.

The CONTRACTOR may express time in regular time (AM or PM) or in military time (using the 24-hour clock); however, the selected method for expressing time (regular or military) shall be used consistently by the CONTRACTOR and by all of the CONTRACTOR's subcontractors, NEMT providers and drivers.

Exhibit C
VEHICLE REQUIREMENTS

All vehicles, except for fixed route vehicles and ambulances, shall meet the following requirements:

1. The number of persons in the vehicle, including the driver, shall not exceed the vehicle manufacturer's approved seating capacity.
2. All vehicles shall have adequately functioning heating and air-conditioning systems.
3. All vehicles shall have functioning, clean and accessible seat belts for each passenger seat position. All vehicles shall have an easily visible interior sign that states: "ALL PASSENGERS SHALL USE SEAT BELTS". Seat belts shall be stored off the floor when not in use.
4. Each vehicle shall use child safety seats in accordance with state law.
5. All vehicles shall have at least two (2) seat belt extensions.
6. For use in emergency situations, each vehicle shall be equipped with at least one (1) seat belt cutter that is kept within easy reach of the driver.
7. All vehicles shall have functioning interior light(s) within the passenger compartment.
8. All vehicles shall have an accurate, operating speedometer and odometer.
9. All vehicles shall have two (2) exterior rear view mirrors, one (1) on each side of the vehicle.
10. All vehicles shall be equipped with an interior mirror for monitoring the passenger compartment.
11. The exterior of all vehicles shall be clean and free of broken mirrors or windows, excessive grime, major dents, or paint damage that detract from the overall appearance of the vehicles.
12. The interior of all vehicles shall be clean and free of torn upholstery, floor or ceiling covering; damaged or broken seats; protruding sharp edges; dirt, oil, grease or litter; or hazardous debris or unsecured items.
13. All vehicles shall be smooth riding, so as not to create passenger discomfort.
14. All vehicles shall have the NEMT provider's business name and telephone number decaled on at least both sides of the exterior of the vehicle. The business name and phone number shall appear in lettering that is a minimum of three inches in height and of a color that contrasts with its surrounding background.
15. To comply with confidentiality requirements, no words may be displayed on the vehicle that implies that TennCare enrollees are being transported. The name of the NEMT provider's business may not imply that TennCare enrollees are being transported.
16. The vehicle license number and the CONTRACTOR's toll-free phone number shall be prominently displayed on the interior of each vehicle. This information and the complaint procedures shall be clearly visible and available in written format (at a minimum, in English and Spanish) in each vehicle for distribution to enrollees upon request.
17. The vehicle shall have a current inspection sticker issued by the CONTRACTOR on the outside of the passenger side rear window in the lower right corner.
18. Smoking shall be prohibited in all vehicles at all times. All vehicles shall have an easily visible interior sign that states: "NO SMOKING".
19. All vehicles shall carry a vehicle information packet containing vehicle registration, insurance card, and accident procedures and forms.

Amendment Number 22 (cont.)

20. All vehicles shall be equipped with a first aid kit stocked with antiseptic cleansing wipes, triple antibiotic ointment, assorted sizes of adhesive and gauze bandages, tape, scissors, latex or other impermeable gloves, and sterile eyewash.
21. Each vehicle shall contain a current map of the applicable geographic area with sufficient detail to locate enrollee and provider addresses.
22. Each vehicle shall be equipped with a regulation size Class B chemical type fire extinguisher. The fire extinguisher shall have a visible, current (up-to-date) inspection tag or sticker showing an inspection of the fire extinguisher by the appropriate authority within the past twelve (12) months. The extinguisher shall be mounted in a bracket located in the driver's compartment and be readily accessible to the driver and passenger(s).
23. Each vehicle shall be equipped with a "spill kit" that includes liquid spill absorbent, latex or other impermeable gloves, hazardous waste disposal bags, scrub brush, disinfectant and deodorizer.
24. Each vehicle shall be equipped with emergency triangles.
25. Each vehicle that is required to stop at all railroad crossings shall have a railroad crossing decal that says that the vehicle stops at all railroad crossings.
26. Each vehicle shall have a real-time link, telephone or two-way radio. Pagers are not acceptable as a substitute.

Exhibit D
DRIVER REQUIREMENTS

The requirements listed below shall apply to all drivers of vehicles other than fixed route vehicles and ambulances.

1. All drivers shall be courteous, patient, and helpful to all passengers.
2. All drivers shall be neat and clean in appearance.
3. No driver shall use alcohol, narcotics, illegal drugs or prescription medications that impair the ability to perform while on duty. No driver shall abuse alcohol or prescription medications or use illegal drugs at any time.
4. All drivers shall wear and have visible an identification badge that is easily readable and identifies the driver and the NEMT provider.
5. No driver shall smoke or eat while in the vehicle, while assisting an enrollee, or in the presence of any enrollee.
6. Drivers shall not wear any type of headphones at any time while on duty, with the exception of hands-free headsets for mobile telephones. Mobile telephones may only be used for communication with the NEMT provider, the dispatcher, or the CONTRACTOR.
7. Drivers shall exit the vehicle to open and close vehicle doors when passengers enter or exit the vehicle.
8. The driver shall provide an appropriate level of assistance to an enrollee when requested or when necessitated by the enrollee's mobility status or personal condition. This includes curb-to-curb, door-to-door, and hand-to-hand service, as required.
9. The driver shall assist enrollees in the process of being seated including the fastening of seat belts, securing children in properly-installed child safety seats, and properly securing passengers in wheelchairs.
10. The driver shall confirm, prior to departure, that all seat belts are fastened properly, and that all passengers, including passengers in wheelchairs, are safely and properly secured.
11. Upon arrival at the destination, the driver shall park the vehicle so that the enrollee does not have to cross streets to reach the entrance of the destination.
12. Drivers shall visually confirm that the enrollee is inside the destination.
13. The driver shall not leave an enrollee unattended at any time.
14. If an enrollee or other passenger's behavior or any other condition impedes the safe operation of the vehicle, the driver shall park the vehicle in a safe location out of traffic, notify the NEMT provider/dispatcher, and request assistance.

Exhibit E
DRIVER LOGS

The CONTRACTOR shall require that the NEMT providers' drivers maintain daily transportation logs containing, at a minimum, the information listed below. Fixed route transportation is excluded from this requirement.

1. Date of service;
2. Driver's name;
3. Driver's signature;
4. Name of escort or accompanying adult (for enrollees under age eighteen (18) and relationship to enrollee (if applicable));
5. Vehicle Identification Number (VIN);
6. Enrollee's name;
7. The NEMT provider's name;
8. Number assigned by the CONTRACTOR for the approved trip;
9. Mode of transportation approved;
10. Actual start time (from the base station) for the time zone applicable to the starting location;
11. Scheduled pick-up time for the time zone applicable to the pick-up location;
12. Actual pick-up location and time for the time zone applicable to the pick-up location;
13. Actual departure time from pick-up location for the time zone applicable to the pick-up location;
14. Actual destination and time for the time zone applicable to the destination;
15. Actual number of wheelchairs, escorts, and accompanying adults (for enrollees under age eighteen (18));
16. Odometer readings at each point of pick-up and of drop-off; and
17. Notes, if applicable. At a minimum, the log shall show notes in the case of cancellations, incomplete requests, "no-shows", accident and incident.

For ambulance, the log shall also contain, at a minimum:

1. Patient assessment by ambulance personnel and a chronological narrative of care/service rendered by ambulance personnel;
2. Itemized list of specialized services and/or supplies; and
3. Type of vehicle used for transport (class or service category).

The CONTRACTOR may express time in regular time (AM or PM) or in military time (using the 24-hour clock); however, the selected method for expressing time (regular or military) shall be used consistently by the CONTRACTOR and by all of the CONTRACTOR's subcontractors, NEMT providers and drivers.

Exhibit F
PERFORMANCE STANDARDS AND LIQUIDATED DAMAGES

No.	PERFORMANCE STANDARD	LIQUIDATED DAMAGE
1	Ensure that members receive the appropriate level of service (see Section A.4.4 of this Attachment)	\$500 per deficiency
2	Comply with the approval and scheduling timeframes (see Section A.5.1.3 of this Attachment)	\$1,000 per deficiency
3	Comply with requirements regarding urgent trips (see Section A.5.7 of this Attachment)	\$500 per deficiency
4	Comply with pick-up and delivery standards (see Section A.6 of this Attachment)	\$100 per deficiency
5	Comply with vehicle standards (see Section A.7 of this Attachment)	<p>\$1,500 per calendar day per vehicle that is not in compliance with ADA requirements</p> <p>\$1,000 per vehicle that is allowed into service without an inspection in accordance with the requirements of the Agreement</p> <p>\$2,500 per calendar day per vehicle that is not in compliance with a vehicle standard that would endanger health or safety for vehicle occupants</p> <p>\$500 per calendar day per vehicle that is not in compliance with a vehicle standard that creates passenger discomfort or inconvenience</p> <p>\$100 per calendar day per vehicle that is not in compliance with an administrative vehicle standard</p>
6	Comply with driver training requirements and driver standards (see Section A.8 of this Attachment)	\$2,500 per calendar day per driver for each calendar day that a driver is not in compliance with the driver standards

Amendment Number 22 (cont.)

No.	PERFORMANCE STANDARD	LIQUIDATED DAMAGE
7	No more than 1% of calls to the NEMT Call Center are blocked (see Section A.9 of this Attachment)	<p>For the first deficiency: \$5,000 for each full percentage point above 1% per month per line/queue</p> <p>For the second deficiency: \$10,000 for each full percentage point above 1% per month per line/queue</p> <p>For the third and subsequent deficiencies: \$15,000 for each full percentage point above 1% per month per line/queue</p>
8	90% of all calls to the NEMT Call Center are answered by a live voice within thirty (30) seconds (see Section A.9 of this Attachment)	<p>For the first deficiency: \$5,000 for each full percentage point below 90% per month per line/queue</p> <p>For the second deficiency: \$10,000 for each full percentage point below 90% per month per line/queue</p> <p>For the third and subsequent deficiencies: \$15,000 for each full percentage point below 90% per month per line/queue</p>
9	Less than 5% of calls to the NEMT Call Center are abandoned (see Section A.9 of this Attachment)	<p>For the first deficiency: \$5,000 for each full percentage point above 5% per month per line/queue</p> <p>For the second deficiency: \$10,000 for each full percentage point above 5% per month per line/queue</p> <p>For the third and subsequent deficiencies: \$15,000 for each full percentage point above 5% per month per line/queue</p>
10	Average hold time for calls to the NEMT Call Center is no more than 3 minutes (see Section A.9 of this Attachment)	<p>For the first deficiency: \$5,000 for each 10 seconds over 3 minutes per month per line/queue</p> <p>For the second deficiency: \$10,000 for each 10 seconds over 3 minutes per month per line/queue</p> <p>For the third and subsequent deficiencies: \$15,000 for each 10 seconds over 3 minutes per month per line/queue</p>
11	Process 90% of clean NEMT claims within thirty (30) calendar days of the receipt of the claim and process 99.5% of claims within sixty (60) calendar of receipt (see Section A.15.3 and Section A.15.4 of this Attachment)	\$10,000 for each month determined not to be in compliance
12	97% of NEMT claims are paid accurately upon initial submission (see Section A.15.5 of this Attachment)	\$5,000 for each full percentage point accuracy is below 97% for each quarter

58. **Attachment XII shall be amended by deleting Attachment XII in its entirety and replacing it with the following and renumbering all references thereto:**

**ATTACHMENT XII
Administrative Fee Payments**

- I. Administrative Fee Effective July 1, 2001 through December 31, 2002

Enrollee Category	Effective July 1, 2001 – June 30, 2002	Effective July 1, 2002 – December 31, 2002
Group 1.A	\$21.84 PMPM	\$22.71 PMPM
Group 1.B	\$21.84 PMPM	\$22.71 PMPM
Group 2	\$21.84 PMPM	\$22.71 PMPM
Group 3	\$13.84 PMPM	\$14.39 PMPM
Group 4	\$13.84 PMPM	\$14.39 PMPM
Group 5	\$13.84 PMPM	\$14.39 PMPM
Group 6	\$13.84 PMPM	\$14.39 PMPM

- II. Administrative Fee Effective January 1, 2003:

Group 1.A, Group 1.B, and Group 2

Enrollee Category	Effective January 1, 2003
Group 1.A	\$25.00 PMPM
Group 1.B	\$25.00 PMPM
Group 2	\$25.00 PMPM

Group 3, Group 4, Group 5 and Group 6 shall vary based on the total number of enrollees in these groups as follows:

Enrollment Level	Administrative Fee
0 to 99,999 enrollees	\$11.37
100,000 to 199,999 enrollees	\$11.25
200,000 to 299,999 enrollees	\$11.12
300,000 to 399,999 enrollees	\$11.00
400,000 to 499,999 enrollees	\$10.89
500,000 to 599,999 enrollees	\$10.68
600,000 to 699,999 enrollees	\$10.53
700,000 to 799,999 enrollees	\$10.38
800,000 to 899,999 enrollees	\$10.23
900,000 to 999,999 enrollees	\$10.08
1,000,000 or more enrollees	\$9.93

- III. Administrative Fee Effective January 1, 2006:

Group 1.A, Group 1.B, and Group 2

Enrollee Category	Effective January 1, 2003
Group 1.A	\$25.20 PMPM
Group 1.B	\$25.20 PMPM
Group 2	\$25.20 PMPM

Group 3, Group 4, Group 5 and Group 6 shall vary based on the total number of enrollees in these groups as follows:

Enrollment Level	Administrative Fee
0 to 99,999 enrollees	\$11.57
100,000 to 199,999 enrollees	\$11.45
200,000 to 299,999 enrollees	\$11.32
300,000 to 399,999 enrollees	\$11.20
400,000 to 499,999 enrollees	\$11.09
500,000 to 599,999 enrollees	\$10.88
600,000 to 699,999 enrollees	\$10.73
700,000 to 799,999 enrollees	\$10.58
800,000 to 899,999 enrollees	\$10.43
900,000 to 999,999 enrollees	\$10.28
1,000,000 or more enrollees	\$10.13

IV. Administrative Fee Effective September 1, 2009

Enrollee Category	Effective September 1, 2009
Group 1.A	\$29.00 PMPM
Group 1.B	\$29.00 PMPM
Group 2	\$29.00 PMPM
Group 3	\$29.00 PMPM
Group 4	\$29.00 PMPM
Group 5	\$29.00 PMPM
Group 6	\$29.00 PMPM

V. Administrative Fee Effective Upon Implementation of the Integrated Health Services Delivery Model

Enrollee Category	Effective Upon Implementation of the Integrated Health Services Delivery Model
Group 1.A	\$29.00 PMPM
Group 1.B	\$29.00 PMPM
Group 2	\$29.00 PMPM
Group 3	\$29.00 PMPM
Group 4	\$29.00 PMPM
Group 5^{IHSDM}	TennCare shall reimburse actual and reasonable costs associated with the management and delivery of covered services for this population as specified in Section 4.1.6.
Group 5	\$29.00 PMPM
Group 6	\$29.00 PMPM

- 59. Attachment XIII through XVI shall be amended by deleting them in their entirety and renumbering all references thereto.**
- 60. All Sections of the Agreement shall be amended to renumber references in accordance with this Amendment.**

Amendment Number 22 (cont.)

All of the provisions of the original Agreement not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective March 1, 2010.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: M.D. Goetz, Jr. / sv
M. D. Goetz, Jr.
Commissioner

DATE: 2/19/10

VOLUNTEER STATE HEALTH PLAN,
INC.

BY: Sonya Nelson
Sonya Nelson
President and Chief Executive Officer

DATE: 2/14/10

APPROVED BY:

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: M.D. Goetz, Jr. / sv
M. D. Goetz, Jr.
Commissioner

DATE: 3/1/10

APPROVED BY:

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

BY: Justin P. Wilson
Justin P. Wilson
Comptroller

DATE: 4/14/10

CONTRACT SUMMARY SHEET

RFS Number:	318.66-026	Contract Number:	FA-02-14632-21
State Agency:	Department of Finance and Administration	Division:	Bureau of TennCare

Contractor	Contract Identification Number
VSHP (TennCare Select)	<input type="checkbox"/> V- <input type="checkbox"/> C-

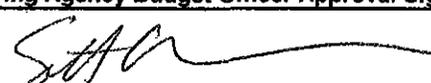
Service Description

Managed Care Organization / Medically Necessary Health Care Services to the TennCare

Contract Begin Date	Contract End Date
7/1/2001	6/30/2010

Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66	4A2	134	11	<input type="checkbox"/> STARS		
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)	
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$ 18,599,868.48	
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$ 33,079,942.80	
2004	\$ 25,125,990.72	\$ 38,364,165.90			\$ 63,490,156.62	
2005	\$ 58,007,447.00	\$ 58,007,447.00			\$ 116,014,894.00	
2006	\$87,748,111.00	\$87,748,111.00			\$175,496,222.00	
2007	\$87,748,111.00	\$87,748,111.00			\$175,496,222.00	
2008	\$72,610,000.00	\$127,390,000.00			\$200,000,000.00	
2009	\$72,610,000.00	\$127,390,000.00			\$200,000,000.00	
2010	\$99,786,219.00	\$300,720,381.00			\$400,506,600.00	
Total:	\$ 526,176,939.35	\$ 856,506,966.55			\$1,382,683,905.90	

CFDA#	93.778 Title XIX Dept. of Health & Human Svcs.	Check the box ONLY if the answer is YES:
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State Fiscal Contract		
Name:	Scott Pierce	Is the Contractor a SUBRECIPIENT? (per OMB A-133)
Address:	310 Great Circle Road	Is the Contractor a Vendor? (per OMB A-133)
Phone:	Nashville, TN (615)507-6415	Is the Fiscal Year Funding STRICTLY LIMITED?
Procuring Agency Budget Officer Approval Signature		Is the Contractor on STARS?
Scott Pierce		Is the Contractor's FORM W-9 ATTACHED?
		Is the Contractor's Form W-9 Filed with Accounts?

COMPLETE FOR ALL AMENDMENTS (only)			Funding Certification
	Base Contract & Prior Amendments	This Amendment ONLY	
CONTRACT END DATE:	6/30/2010		Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.
FY: 2002	\$ 18,599,868.48		
FY: 2003	\$ 33,079,942.80		
FY: 2004	\$ 63,490,156.62		
FY: 2005	\$116,014,894.00		
FY: 2006	\$175,496,222.00		
FY: 2007	\$175,151,878.00		
FY: 2008	\$200,000,000.00		
FY: 2009	\$200,000,000.00		
FY: 2010	\$383,130,000.00	\$17,376,600.00	
Total:	\$1,365,307,305.90	\$17,376,600.00	

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OPERATIONAL SUPPORT
MANAGEMENT SERVICES

AMENDMENT NUMBER 21

**AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.**

CONTRACT NUMBER: FA-02-14632-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as follows:

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. Section 2.4.4.1.1 shall be amended by adding a new Section 2.4.4.1.1.4 "Group 5 ^{IHSDM}: Persons with Intellectual Disabilities who have been defined as the Target Population for the Integrated Health Services Delivery Model described in Section 3A of this Agreement;" and renumbering the existing Sections and eligibility Groups accordingly, including any references thereto throughout the Agreement.

2. The Select Contract shall be amended by adding a new Section 3A. For greater clarity, this new Section 3A is a separate and distinct section from Section 3.

3. The new Section 3A shall read as follows:

3A INTEGRATED HEALTH SERVICES DELIVERY MODEL FOR PERSONS WITH INTELLECTUAL DISABILITIES (i.e., Mental Retardation)

3A.1 General

3A.1.1 Notwithstanding any provision in this Agreement to the contrary, the CONTRACTOR shall be responsible for the implementation of an Integrated Health Services Delivery Model for persons with intellectual disabilities as set forth in this Section.

The model as defined herein includes the following:

3A.1.1.1 Continuous assessment of each member's physical and behavioral health needs including preventive care needs, acute and chronic physical or behavioral health conditions, and related problems specific or common to persons with Intellectual and/or Developmental Disabilities (I/DD);

- 3A.1.1.2 Timely access to medically necessary physical and behavioral health care services;
- 3A.1.1.3 Implementation of a person-centered Medical Home Model for primary care and coordination of medical information and specialized physical and behavioral health care needs by a Primary Care Physician;
- 3A.1.1.4 Ongoing coordination with long-term care services the member receives, including Home and Community Based Services (HCBS) provided under a Section 1915(c) waiver program for persons with intellectual disabilities (i.e., mental retardation) or Institutional services in an Intermediate Care Facility for persons with Mental Retardation (ICF/MR) or Nursing Facility (NF), as applicable; and
- 3A.1.1.5 Continuous collaboration between the member's care providers and payors, including TennCare, the Tennessee Department of Finance & Administration - Division of Intellectual Disabilities Services (DIDS, formerly known as DMRS), and the CONTRACTOR who will be responsible for the coordination, delivery and payment of all medically necessary covered physical and behavioral health services.

3A.1.2 The Integrated Health Services Delivery Model shall be efficient in terms of both administration and cost, shall minimize duplicative administrative functions and expenses, and shall maximize federal financial participation in both administrative and service-related expenditures for eligible service recipients.

3A.1.3 The cornerstone of the model is Nurse Care Management, which shall be provided by the CONTRACTOR as an administrative service, rather than a covered benefit. Each TennCare Select member within the target population shall have an assigned Nurse Care Manager. Nurse Care Managers shall develop an individualized, Integrated Plan of Health Care for each member, coordinate the full array of covered physical and behavioral health services eligible members need, and work closely with Independent Support Coordinators or Waiver Case Managers, as applicable and MR Waiver, ICF/MR and/or NF providers in implementing the Integrated Plan of Health Care which operates in conjunction with the member's Individual Support Plan. In addition to extensive professional nursing experience and expertise, Nurse Care Managers will receive training specific to the I/DD population, with particular focus on medical issues common in occurrence and nursing procedures frequently required for the I/DD population.

3A.2 Target Population for the Integrated Health Services Delivery Model

3A.2.1 Upon implementation of the Integrated Health Services Delivery Model for persons with intellectual disabilities and in accordance with the phased-in implementation plan set forth in this Section, the CONTRACTOR shall provide Nurse Care Management care services to all TennCare Select members with intellectual disabilities who are actively enrolled in one of the State of Tennessee's three (3) Section 1915(c) Home and Community Based Services (HCBS) waiver programs for persons with intellectual disabilities (i.e., mental retardation), including the Arlington, Statewide (or "Main") and Self-Determination Waiver Programs.

3A.2.2 The CONTRACTOR shall also provide Nurse Care Management services to all TennCare Select members with intellectual disabilities receiving ICF/MR services in a private (i.e., non-State) Intermediate Care Facility for persons with Mental Retardation (ICF/MR), as well as TennCare

Select members in the Arlington Class who are residing in public or private ICFs/MR, nursing homes or in other institutional or alternative home and community-based placements, which may include the person's (or family's) home, except that persons enrolled in the CHOICES program shall not participate in the Integrated Health Services Delivery Model.

3A.2.3 The CONTRACTOR shall provide Nurse Care Management *only* to members of the target population as defined in this Section. Nurse Care Management shall not be available to persons outside the defined target population for the Integrated Health Services Delivery Model.

3A.2.4 TENNCARE will notify the CONTRACTOR regarding Arlington Class Members currently served by the Community Services Network (CSN) who elect to opt into TennCare Select and participate in the Integrated Health Services Delivery Model.

3A.2.5 For other members of the target population, TENNCARE will notify the CONTRACTOR via the 834 eligibility file when the member has been enrolled in TennCare Select, either because:

- (a) s/he is in the defined target population and has elected to opt into TennCare Select; or
- (b) because s/he has been auto-assigned (with an opt out provision) by virtue of being a new TennCare member who meets ICF/MR level of care eligibility and is:
 - (1) actively enrolled in an MR Waiver program; or
 - (2) receiving ICF/MR services; or
 - (3) a member of the Arlington At-Risk Class.

Additional notification processes may be established as necessary to help facilitate timely initiation of the CONTRACTOR's care management (including assessment) activities; however, only members assigned to TennCare Select by TennCare (i.e., based on auto-assignment or an MCO change request) may participate in the Integrated Health Services Delivery Model.

3A.3 Phased-In Implementation of the Integrated Health Services Delivery Model

3A.3.1 In order to ensure a seamless transition of care for persons transitioning from CSN to the Integrated Health Services Delivery Model and to ensure the availability of resources needed to expand the model beyond Arlington Class Members, the Integrated Health Services Delivery Model shall be phased in as follows:

3A.3.2 Approximately 120 days following approval by the federal court, TennCare shall begin transitioning Arlington Class Members currently receiving services through CSN as set forth under Section 3A.19 *Transition of Members Currently Receiving Care Through the Community Services Network*.

3A.3.3 Approximately 120 days later, TennCare shall begin expanding the model to other members of the target population, on a Grand Region by Grand Region basis, until all persons in the target population have been given an opportunity to opt into TennCare Select and participate in the Integrated Health Services Delivery Model. At TennCare's discretion, notice and transition processes for other members of the target population may be scheduled to facilitate a more seamless transition process. TennCare shall also begin auto assigning new TennCare members in the target population to TennCare Select with the ability to opt out into a different health plan.

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3A.3.4 All members of the target population assigned to TennCare Select shall be assigned to the Integrated Health Services Delivery Model.

3A.4 Nurse Care Management

3A.4.1 The CONTRACTOR shall provide Nurse Care Management in an integrated, holistic, person-centered manner.

3A.4.1.1 Nurse Care Management shall be the continuous process of:

3A.4.1.2 Assessing a member's physical and behavioral health needs;

3A.4.1.3 Identifying the covered physical and behavioral health services that are necessary to meet the member's identified needs;

3A.4.1.4 Developing and maintaining for each member an individualized, Integrated Plan of Health Care (which shall specify physical as well as behavioral health services and interventions);

3A.4.1.5 Ensuring timely access to and provision, coordination and monitoring of covered physical and behavioral health services; and

3A.4.1.6 Collaboration between providers and payors of the member's physical and behavioral health services, including physicians and other physical and behavioral health care providers, TennCare, DIDS, and the CONTRACTOR to facilitate seamless access to care and maximize health outcomes.

3A.4.2 The CONTRACTOR shall develop and implement policies and procedures for Nurse Care Management which comport with the requirements of this Section.

3A.4.2.1 Such policies and procedures shall specify the role and authority of Nurse Care Managers in authorizing needed physical and behavioral health services. At the discretion of the CONTRACTOR, authorization of home health, private duty nursing, and direct therapy services (i.e., occupational, physical and speech therapy services) may be completed by the Nurse Care Manager or through the CONTRACTOR's established UM processes but shall be coordinated by the Nurse Care Manager to ensure timely access to needed care and coordination with MR Waiver benefits.

3A.4.3 The CONTRACTOR shall ensure that, upon enrollment into the Integrated Health Services Delivery Model, MCO case management and/or disease management activities for the target population are integrated with Nurse Care Management processes and functions, and that the member's assigned Nurse Care Manager has primary responsibility for coordination of all the member's physical and behavioral health needs. The Nurse Care Manager may use resources and staff from the CONTRACTOR's case management and disease management programs, including persons with specialized expertise in areas such as behavioral health, to supplement but not supplant the role and responsibilities of the Nurse Care Manager.

3A.4.4 The CONTRACTOR shall utilize state-of-the-art care management tools, health informatics and analytics to stratify populations, target physical and behavioral health interventions, and to

identify and address gaps in care based on best practice protocols for managing specific conditions.

3A.5 Assignment of a Nurse Care Manager to Members NOT Transitioning from the Community Services Network

3A.5.1 The CONTRACTOR shall, within five (5) business days after notification of enrollment of each new member in the target population not transitioning from the Community Services Network into TennCare Select, assign a specific Nurse Care Manager who shall have primary responsibility for performance of Nurse Care Management activities as specified in this Section, and who shall be the member's point of contact for coordination of physical and behavioral health services. (Members transitioning from CSN shall have a Nurse Care Manager assigned prior to transition.)

3A.5.2 The CONTRACTOR shall, within ten (10) business days after notification of enrollment of each new member in the target population into TennCare Select, provide written notice to the member including the name and contact information for his/her assigned Nurse Care Manager, and how to obtain assistance for urgent physical and behavioral health needs after hours.

3A.5.3 The CONTRACTOR may utilize a care management support team approach to performing Nurse Care Management activities. For each participant in the Integrated Health Services Delivery model, the CONTRACTOR's Care Management Support Team shall consist of the member's Nurse Care Manager and specific other persons with relevant expertise and experience appropriate to address the needs of persons with I/DD. Care Management Support Teams shall be discrete entities within the CONTRACTOR's organizational structure dedicated to fulfilling Nurse Care Management functions. The CONTRACTOR shall establish policies and procedures which specify, at a minimum: the composition of care management support teams; the tasks that will be performed directly by the Nurse Care Manager, which shall include all assessments and face-to-face contacts; measures taken to ensure that the Nurse Care Manager remains the member's primary point of contact for physical and behavioral health needs; escalation procedures to elevate issues to the Nurse Care Manager in a timely manner; and measures taken to ensure that if a member needs to reach his/her Nurse Care Manager specifically, calls that require immediate attention by a Nurse Care Manager are handled by a Nurse Care Manager and calls that do not require immediate attention are returned by the member's Nurse Care Manager the next business day.

3A.6 Assessment of Physical and Behavioral Health Needs

3A.6.1 The CONTRACTOR shall conduct a comprehensive face-to-face assessment of each member’s physical and behavioral health needs, including a comprehensive physical, behavioral, developmental, and social history; identification of all current physical or behavioral health conditions or symptoms, treatments and interventions, including currently administered prescription and over-the-counter medications; an assessment of the current status of preventive care; a thorough review of relevant physiological needs, including but not limited to gastrointestinal function, skin integrity, seizure disorders, bowel and bladder function, and nutrition and/or weight-related concerns; an assessment of any Durable Medical Equipment (DME) needs, including whether existing DME items are in good working condition and appropriate for the member’s needs—both in terms of fit and functionality; and identification of key physical and behavioral health-related risks.

3A.6.1.1 For persons transitioning into the Integrated Health Services Delivery Model from the Community Services Network (CSN), such face-to-face assessment shall be completed prior to transition as set forth under Section 3A.19 *Transition of Members Currently Receiving Care Through the Community Services Network*. For other participants in the Integrated Health Services Delivery Model assigned to TennCare Select or electing to opt into TennCare Select, such face-to-face assessment shall be as soon as possible after enrollment into TennCare Select, but must be completed in time to ensure the development of an individualized, Integrated Plan of Health Care within the timeframes set forth below.

3A.6.1.2 The schedule for the face-to-face assessment shall be coordinated with the member’s guardian or conservator, as applicable, and shall be completed in the member’s place of residence, except under extenuating circumstances (such as the member’s hospitalization), which shall be documented in writing.

3A.6.1.3 The CONTRACTOR shall make reasonable efforts to include the member’s guardian or conservator in the assessment process, and to gather relevant information from the member’s guardian or conservator regarding the member’s physical and/or behavioral health needs.

3A.6.2 Prior to conducting the face-to-face assessment, the CONTRACTOR shall review available data and information regarding the member’s physical and behavioral health care needs and utilization, including but not limited to claims and encounter information (as applicable), Physical Status Reviews, Health Care Plans, Individual Support Plans, and other relevant data provided by DIDS and/or by CSN in order to identify health-related concerns and to help inform and guide the assessment process.

3A.7 Development of an Individualized, Integrated Plan of Health Care

3A.7.1 Upon completion of the assessment, the CONTRACTOR shall coordinate with a Care Management Support Team to develop an individualized, Integrated Plan of Health Care. Such plan shall be completed within thirty (30) calendar days of enrollment into the Integrated Health Services Delivery Model.

3A.7.2 The Care Management Support Team shall be led by the Nurse Care Manager and shall include the member and his/her family, guardian or conservator (as applicable). The Team may also

include (as appropriate), but is not limited to the member's Primary Care Physician, Independent Support Coordinator (ISC) or Waiver Case Manager (WCM), as applicable, MR Waiver providers, DIDS Advocate, physical and/or behavioral health care providers, and other VSHP staff such as the physical or behavioral health Medical Director(s), Social Worker, etc.

3A.7.3 Nurse Care Managers shall consult with the member's PCP, specialists, behavioral health providers, other providers, and interdisciplinary team experts, as needed when developing the Integrated Plan of Health Care.

3A.7.4 The Integrated Plan of Health Care shall include, at a minimum:

3A.7.4.1 Pertinent demographic information regarding the member including the name and contact information of the guardian or conservator and a list of other persons authorized by the member to have access to health care related information and to assist with assessment, planning, and/or implementation of health care related services and supports;

3A.7.4.2 Description of any special communication needs including interpreters or special devices;

3A.7.4.3 The Primary Care Physician and his/her contact information;

3A.7.4.4 A summary of key information from the assessment, including relevant physical, behavioral, developmental, and/or social history; current physical or behavioral health conditions or symptoms, treatments and interventions; the current status of preventive care; and relevant physiological and DME needs;

3A.7.4.5 Health (including mental health)-related goals, objectives and desired health, functional, and quality of life outcomes for the member;

3A.7.4.6 A description of the member's physical and behavioral health needs, including a description of medical equipment used or needed by the member (if applicable);

3A.7.4.7 Physical or behavioral health risks and appropriate interventions and strategies to mitigate those risks;

3A.7.4.8 Any steps caregivers should take in the event of an emergency that differ from the standard emergency protocol;

3A.7.4.9 The physical and behavioral health services and interventions that are necessary to meet the member's identified needs;

3A.7.4.10 Health care tasks and functions that will be performed by family members and other caregivers, such as routine administration of medications;

3A.7.4.11 A detailed listing of the physical and behavioral health services the member will receive from other payor sources including the payor of such services (e.g., Medicare home health);

3A.7.4.12 A detailed listing of covered physical and behavioral health services to be provided by the CONTRACTOR, including preventive services;

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- 3A.7.4.13 When home health and/or private duty nursing services will be authorized by the CONTRACTOR, a detailed and adequate back-up plan for situations when regularly scheduled HH/PDN providers are unavailable or do not arrive as scheduled (the back-up plan may include paid and unpaid supports and shall include the names and telephone numbers of persons and agencies to contact and the services provided by listed contacts); and
- 3A.7.4.14 Frequency of planned Nurse Care Management contacts needed, which shall include consideration of the member's individualized needs and circumstances, and which shall at minimum meet required contacts as specified in this Section (unplanned Care Manager contacts shall be provided as needed).
- 3A.7.5 During the development of the member's Integrated Plan of Health Care, the Nurse Care Manager shall educate the member and his/her guardian or conservator, as applicable regarding end of life care and his/her ability to use advance directives and shall document the member's decision in the member's Integrated Plan of Health Care.
- 3A.7.6 For persons residing in Institutional Placements, the Integrated Plan of Health Care shall supplement the facility's plan of care (which is required pursuant to federal regulation), and shall focus on the provision of services covered by TennCare Select that are beyond the scope of the Institutional ICF/MR or NF benefit, including targeted strategies related to improving health, functional, or quality of life outcomes (e.g., related to disease management or pharmacy management) or to increasing and/or maintaining health and/or functional status, as appropriate.
- 3A.7.7 The member's Nurse Care Manager shall participate as appropriate in the Institutional facility's care planning process and advocate for the member regarding physical and behavioral health needs.
- 3A.7.8 The member's Nurse Care Manager shall ensure that the member (and/or his/her guardian or conservator, as appropriate) reviews, signs and dates the Integrated Plan of Health Care as well as any updates.
- 3A.7.9 The CONTRACTOR shall develop policies and procedures that describe the measures taken by the CONTRACTOR to address instances when a member (or his/her guardian or conservator, as appropriate) refuses to sign the plan of care. The policies and procedures shall include a specific escalation process (ultimately to TENNCARE) that includes a review of the reasons for the refusal as well as actions taken to resolve any disagreements with the Integrated Plan of Health Care.
- 3A.7.10 The member's Nurse Care Manager shall provide a copy of the member's completed Integrated Plan of Health Care, including any updates, to the member, the member's guardian or conservator, as applicable, the MR Waiver ISC or Case Manager, and the member's community residential alternative provider, as applicable. The member's Nurse Care Manager/Care Management Support Team shall provide copies to other providers authorized to deliver care to the member upon request, and shall ensure that such physical and behavioral health care providers who do not receive a copy of the Integrated Plan of Health Care are informed in writing of all relevant information needed to ensure the provision of quality physical and behavioral health services for the member.

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3A.7.11 The CONTRACTOR shall immediately begin to address all urgent physical and behavioral health care needs, and shall not wait for completion of the Integrated Plan of Health Care to arrange urgently needed care.

3A.7.12 If the CONTRACTOR is unable to initiate in a timely manner any covered physical or behavioral health service needed by the member that is within the scope of benefits available under the TennCare 1115 Waiver program, the CONTRACTOR shall, pursuant to established *Grier* notice requirements and templates, issue written notice to the member, documenting the service(s) that will be delayed, the reasons for the delay, and the date the service(s) will start, and shall make good faith efforts to ensure that services are provided as soon as practical.

3A.7.13 The CONTRACTOR shall provide to TennCare a monthly report of all delays in service notices issued to participants in the Integrated Health Services Delivery Model, which shall specify at a minimum, the member's name and Medicaid ID, the type of service delayed, the date the service was authorized, the date the notice of delay was issued, the reason for the delay, and the projected date that the service will be available.

3A.7.14 Nurse Care Managers shall 1) timely communicate to Arlington Class members' Independent Support Coordinator and/or Advocate, as applicable, all TennCare Select denials of service which trigger due process appeal rights pursuant to the *Grier* Revised Consent Decree; and 2) provide a copy of the notice of action.

3A.8 Reassessments of Need and Updates to the Integrated Plan of Health Care

3A.8.1 The Nurse Care Manager shall reassess physical and behavioral health needs at least annually and within ten (10) business days of the CONTRACTOR's becoming aware that the member's functional, physical, or behavioral status has changed significantly which may include, but is not limited to:

3A.8.1.1 An acute hospital admission or Emergency Department utilization;

3A.8.1.2 A newly diagnosed physical or behavioral health condition;

3A.8.1.3 A significant change in an existing physical or behavioral health condition;

3A.8.1.4 A significant decline in functional status, such as loss of mobility; or

3A.8.1.5 Behavioral destabilization, including new or increased self-injurious behaviors, property destruction, etc.

3A.8.2 The Nurse Care Manager shall update the Integrated Plan of Health Care as needed to reflect significant changes in condition, treatments or interventions; physical and behavioral health needs, risks and interventions; physical and behavioral health services, etc.

3A.9 Assignment of a Primary Care Physician and Establishment of a Medical Home

3A.9.1 Upon enrollment into TennCare Select, each participant in the Integrated Health Services Delivery Model shall be assigned a Primary Care Physician (PCP), including members dually eligible for TennCare and Medicare.

- 3A.9.1.1 Assignment of the PCP shall, to the maximum extent possible and appropriate, be consistent with the member's current utilization of primary care services, if applicable, so long as such PCP participates in the TennCare Select network.
- 3A.9.1.2 To the extent that (1) a newly enrolled member wishes to utilize a different PCP; (2) a member is not utilizing primary care services upon enrollment into TennCare Select; or (3) a member's current PCP elects not to participate in the TennCare Select network, the member's Nurse Care Manager shall coordinate with the member and his/her guardian or conservator to select a participating PCP who will be assigned to the member.
- 3A.9.1.3 The PCP shall be responsible for continuous comprehensive primary care and coordination of medical information and specialized physical and behavioral health care services, including specialty referrals.
- 3A.9.2 The Nurse Care Manager shall coordinate with the PCP to provide information, address needs and concerns, ensure timely access to needed specialty care, and to facilitate a comprehensive, holistic, person-centered approach to care, and shall provide assistance as needed in scheduling needed appointments, and in arranging non-emergency transportation services.
- 3A.9.3 The CONTRACTOR shall be responsible for helping to facilitate access to and utilization of appropriate preventive care services, which shall include maintenance of an internal tracking system which identifies preventive care status and pending preventive care due dates for each participant in the Integrated Health Services Delivery Model, and screening services provided in accordance with nationally accepted standards or guidelines develop or endorsed by respected medical organizations such as the Centers for Disease Control and Prevention, including but not limited to pap smears, mammograms, prostate cancer screenings, and colorectal cancer screenings, as applicable. Nurse Care Managers shall utilize such tracking system to facilitate timely access to needed care, which may include as needed assistance in scheduling needed appointments, and in arranging non-emergency medical transportation services.
- 3A.9.4 The CONTRACTOR shall monitor utilization of Emergency Department services in an effort to identify physical or behavioral health care needs, ensure appropriate utilization of Primary and/or Specialty Care, improve continuity of care, and to help establish the medical home.
- 3A.10 Transitions of Care**
- 3A.10.1 Nurse Care Managers shall have an integral role in all care transitions, including discharge from an inpatient acute or psychiatric hospital setting, transition from an Institutional to HCBS setting, transitions between Institutional settings, and transitions between community residential providers. The Nurse Care Manager shall work with the discharge planner, ISC or Waiver Case Manager (as applicable), and guardian or conservator (as applicable) to determine the physical and/or behavioral health services that will be needed upon discharge or transition (as applicable), and to ensure that such services are arranged and provided in a timely manner.
- 3A.10.2 For members receiving home health, private duty nursing, or occupational, physical or speech therapy services upon transition, the Nurse Care Manager shall monitor to ensure that such services are implemented timely and in accordance with the Integrated Plan of Health Care.
- 3A.10.3 Upon implementation of the Electronic Visit Verification (EVV) system in the CHOICES in Long-Term Care Program, such monitoring shall include using the EVV system to monitor the

initiation and daily provision of services in accordance with the member's Integrated Plan of Health Care, and immediate action to resolve any service gaps.

3A.11 Monitoring Provision of Physical and Behavioral Health Services

3A.11.1 Upon the scheduled initiation of physical or behavioral health services identified in the Integrated Plan of Health Care, the member's Nurse Care Manager/Care Management Support Team shall begin monitoring to ensure that services have been initiated and continue to be provided as authorized.

3A.11.2 Upon implementation of the Electronic Visit Verification system as required for the CHOICES program, such monitoring shall include ongoing monitoring via electronic visit verification to ensure that services entered into the EVV, i.e., home health services, private duty nursing, and occupational, physical and speech therapy services covered under the TennCare 1115 Waiver program, are provided in accordance with the member's Integrated Plan of Health Care, including the amount, frequency, duration and scope of each service, in accordance with the member's service schedule; and that services continue to meet the member's needs.

3A.11.3 The Nurse Care Manager shall identify and immediately address service gaps, ensure that back-up plans are implemented and effectively working, and evaluate service gaps to determine their cause and to minimize gaps going forward. The CONTRACTOR shall describe in policies and procedures the process for identifying, responding to, and resolving service gaps in a timely manner.

3A.11.4 The Nurse Care Manager shall provide assistance in resolving concerns about service delivery or providers, including the quality of care rendered by providers or Nurse Care Management staff.

3A.12 Other Ongoing Nurse Care Management Responsibilities

3A.12.1 The CONTRACTOR shall provide to contract providers, including but not limited to physicians and behavioral health providers, and caregivers information regarding the role of the Nurse Care Manager and shall request that providers and caregivers notify a member's Nurse Care Manager, as expeditiously as warranted by the member's circumstances, of any significant changes in the member's condition or care, hospitalizations, or recommendations regarding physical or behavioral health services that may be needed.

3A.12.2 The CONTRACTOR shall have systems in place to facilitate timely communication between internal departments and the Nurse Care Manager to ensure that each Nurse Care Manager receives all relevant information regarding his/her members, e.g., member services, disease management, utilization management, and claims processing. The Nurse Care Manager shall follow-up on this information as appropriate, e.g., documentation in the member's plan of care, monitoring of outcomes, and, as appropriate, needs reassessment and updating the plan of care.

3A.12.3 The CONTRACTOR shall monitor and evaluate a member's Emergency Department and behavioral health crisis service utilization to determine the reason for these visits. The Nurse Care Manager shall take appropriate action to facilitate appropriate utilization of these services, e.g., communicating with the member's providers, educating the member, conducting a needs reassessment, and/or updating the member's Integrated Plan of Health Care and to better manage the member's physical health or behavioral health condition(s).

3A.12.4 The CONTRACTOR shall develop policies and procedures to ensure that Nurse Care Managers are actively involved in discharge planning when a member is hospitalized. The CONTRACTOR shall define circumstances that require that hospitalized members receive a face-to-face visit to complete a needs reassessment and an update to the member's Integrated Plan of Health Care as needed.

3A.12.5 The Nurse Care Manager/Care Management Support Team shall coordinate with Medicare payers, Medicare Advantage plans, and Medicare providers as appropriate to coordinate the care and benefits of members who are also eligible for Medicare. In accordance with the State's Coordination of Benefits Agreement with the Centers for Medicare and Medicaid Services (CMS), TENNCARE shall establish a process for sharing Medicare Parts A and B claims data with the CONTRACTOR in order to facilitate a more complete picture of health care services provided to dual eligible members, and to further improve coordination and quality of care for members.

3A.13 Minimum Nurse Care Manager Contacts

3A.13.1 The Nurse Care Manager shall conduct all needs assessment and care planning activities, and shall make all minimum care management contacts in the member's place of residence, except under extenuating circumstances (such as assessment and care planning conducted during the member's hospitalization, or upon the member's request), which shall be documented in writing.

3A.13.2 The CONTRACTOR shall ensure that Nurse Care Managers assess each member's need for contact with the Nurse Care Manager to ensure that the member's physical and behavioral health needs are met.

3A.13.3 At a minimum, members participating in the Integrated Health Services Delivery Model with complex unstable physical or behavioral health needs shall be visited in their residence face-to-face by their Nurse Care Manager at least monthly.

3A.13.4 At a minimum, members participating in the Integrated Health Services Delivery Model with complex stable physical or behavioral health needs shall be contacted by their Nurse Care Manager at least monthly either in person or by telephone, and shall be visited in their residence face-to-face by their Nurse Care Manager at least quarterly.

3A.13.5 At a minimum, members participating in the Integrated Health Services Delivery Model with no complex physical or behavioral health needs shall be contacted by their Nurse Care Manager at least quarterly either in person or by telephone, and shall be visited in their residence face-to-face by their Nurse Care Manager at least semi-annually.

3A.13.6 The CONTRACTOR shall ensure that at each face-to-face visit the Nurse Care Manager makes the following observations and documents the observations in the member's file:

3A.13.6.1 Member's physical condition including observations of the member's skin, weight changes and any visible signs or symptoms of physical illness;

3A.13.6.2 Member's mood and emotional well-being;

3A.13.6.3 Member's satisfaction with physical and behavioral health services;

- 3A.13.6.4 A statement by the member regarding any physical or behavioral health concerns or questions;
- 3A.13.6.5 A statement from the member's guardian and/or conservator regarding any concerns or questions (when the guardian/conservator is available); and
- 3A.13.6.6 Member's upcoming physical and behavioral health appointments.

3A.14 Nurse Care Management Staff

- 3A.14.1 At a minimum, Nurse Care Managers for Arlington class members in the Integrated Health Services Delivery Model shall be a Registered Nurse with at least three (3) years professional nursing experience and a minimum of two (2) years experience providing care management (preferably in a managed care setting). The CONTRACTOR shall use best efforts to employ Nurse Care Managers with appropriate certifications including Certified Case Manager (CCM) and Developmental Disabilities (DD) Certification. Nurse Care Managers who meet established qualifications but are not certified upon employment shall be required to take the certification exam(s) upon obtaining the required minimum experience.
 - 3A.14.1.1 The CONTRACTOR shall use its best efforts to recruit and employ nurse case managers employed by CSN who pass the background checks and meet the contractual educational and experiential requirements for Nurse Care Managers for Arlington Class members participating in the IHSD model.
- 3A.14.2 At a minimum, Nurse Care Managers for other participants in the Integrated Health Services Delivery Model shall be a Registered or Licensed nurse with at least (2) years professional nursing experience. Nurse Care Managers with less than three (3) years professional nursing experience and/or less than two (2) years providing care management, and all Licensed (but not Registered) Nurses shall have a Registered Nurse Supervisor who meets minimum qualifications for Nurse Care Management for Arlington class members. All Nurse Care Managers who meet established qualifications but are not CCM and DD certified upon employment shall be encouraged to complete such certification(s) upon obtaining the required minimum experience.
- 3A.14.3 The CONTRACTOR shall ensure an adequate number of Nurse Care Managers are available and that sufficient staffing ratios are maintained to address the needs of participants in the Integrated Health Services Delivery Model and to meet all requirements described in this Section.
- 3A.14.4 For Arlington class members transitioning into the Integrated Health Services Delivery Model from CSN, the Nurse Care Manager-to-member ratio shall not exceed 1:15 for any member during the pre-implementation and first ninety (90) days post-implementation phase. Once assessments have been completed and all CSN members are successfully transitioned into the Integrated Health Services Delivery Model, information regarding members gathered through assessment UM, and other processes as well as predictive modeling may be utilized to help identify members with the most significant health and/or behavioral health needs who are at the highest risk and who offer the greatest potential for improvements in health outcomes, and to stratify members and prioritize Nurse Care Manager resources accordingly, such that individual Nurse Care Managers may have a greater or lesser number of assigned members based on the level of need of such members. For a period of two (2) years following implementation of the Integrated Health Services Delivery Model, the average Nurse Care Manager-to-member ratio shall not exceed 1:35 for Arlington class members who are not in an ICF/MR or other institutional placement.

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- 3A.14.5 Similar processes shall be used for identification, stratification, and prioritization of other participants in the Integrated Health Services Delivery Model, with more intensive staffing during the post-enrollment phase, after which time individual Nurse Care Managers may have a greater or lesser number of assigned members based on the level of need of such members.
- 3A.14.6 The CONTRACTOR shall monitor staffing ratios and adjust ratios as necessary to ensure that Nurse Care Managers are able to meet the requirements of this Section and address members' needs.
- 3A.14.7 The CONTRACTOR shall provide, at least sixty (60) days prior to implementation of the Integrated Health Services Delivery Model, a Nurse Care Management Staffing Plan, which shall specify the number of Nurse Care Managers, Nurse Care Manager Supervisors, other supporting Care Management Support Team members the CONTRACTOR plans to initially employ. TENNCARE shall notify the CONTRACTOR in writing if the Nurse Care Management Staffing Plan is insufficient and may require modifications to ensure, prior to implementation of the Integrated Health Services Delivery Model, that the CONTRACTOR has sufficient Nurse Care Management staff. After the Integrated Health Services Delivery Model has been implemented, the CONTRACTOR shall notify TENNCARE in writing of substantive changes to its Nurse Care Management Staffing Plan, including a variance of twenty (20) percent or more from the Staffing Plan. TENNCARE may request changes in the CONTRACTOR's Nurse Care Management Staffing Plan at any time it determines that the CONTRACTOR does not have sufficient Nurse Care Management staff to properly and timely perform its obligations under this Agreement.
- 3A.14.8 The CONTRACTOR shall establish a system to assign Nurse Care Managers and to notify the member of his/her assigned Nurse Care Manager's name and contact information.
- 3A.14.9 Nurse Care Managers shall be physically located within each Grand Region of the State to ensure proximity to the member and care providers.
- 3A.14.10 The CONTRACTOR shall ensure that members have a dedicated toll-free telephone number to contact regarding physical or behavioral health services, which shall be staffed by dedicated customer service representatives. The CONTRACTOR shall facilitate transfer (without having to disconnect or place a second call) to a member's Nurse Care Manager or a member of their Care Management Support Team (if applicable) during normal business hours. If the member's Nurse Care Manager or a member of the member's Care Management Support Team is not available, the call shall be answered by another qualified staff person in the Nurse Care Management unit. The CONTRACTOR shall also ensure access to after-hours assistance for members with urgent physical or behavioral health questions or concerns.
- 3A.14.11 The CONTRACTOR shall permit members to change to a different Nurse Care Manager if the member desires and there is an alternative Nurse Care Manager available. Such availability may take into consideration the CONTRACTOR's need to efficiently deliver Nurse Care Management in accordance with requirements specified herein, including for example, the assignment of a Nurse Care Managers based on the geographic area in which members reside.
- 3A.14.12 In order to ensure quality and continuity of care, the CONTRACTOR shall make efforts to minimize the number of changes in the Nurse Care Manager assigned to a member. Circumstances in which a CONTRACTOR-initiated change in Nurse Care Managers may be appropriate include, but are not limited to, the following:

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- 3A.14.12.1 The Nurse Care Manager is no longer employed by the CONTRACTOR;
 - 3A.14.12.2 The Nurse Care Manager has a conflict of interest and cannot serve the member;
 - 3A.14.12.3 The Nurse Care Manager is on temporary leave from employment; and
 - 3A.14.12.4 Nurse Care Manager caseloads must be adjusted due to the size or intensity of an individual Nurse Care Manager's caseload.
- 3A.14.13 The CONTRACTOR shall develop policies and procedures regarding notice to members of Nurse Care Manager changes initiated by either the CONTRACTOR or the member, including advance notice of planned Nurse Care Manager changes initiated by the CONTRACTOR.
- 3A.14.14 The CONTRACTOR shall ensure continuity of care when Nurse Care Manager changes are made whether initiated by the member or by the CONTRACTOR. The CONTRACTOR shall demonstrate use of best practices by encouraging newly assigned Nurse Care Managers to attend a face-to-face transition visit with the member and the out-going Nurse Care Manager when possible.
- 3A.15 Nurse Care Manager Training**
- 3A.15.1 The CONTRACTOR shall provide competency-based initial training to newly hired Nurse Care Managers and competency-based ongoing training at least annually to all Nurse Care Managers and Supervisors. Initial training topics shall include at a minimum:
- 3A.15.1.1 The Integrated Health Services Delivery Model;
 - 3A.15.1.2 Covered benefits for TennCare Select members;
 - 3A.15.1.3 Section 1915(c) Waiver Programs for Persons with Intellectual Disabilities (i.e., Mental Retardation), including covered benefits and Independent Support Coordination or Case Management, as applicable;
 - 3A.15.1.4 Medicare benefits for dual eligible (i.e., Medicare/Medicaid) members;
 - 3A.15.1.5 Coordination of care among programs, payors and providers;
 - 3A.15.1.6 The Medical Home;
 - 3A.15.1.7 Conducting a comprehensive assessment of physical and behavioral health needs, and development and implementation of an Integrated Plan of Health Care;
 - 3A.15.1.8 Development and implementation of back-up plans for home health and private duty nursing services;
 - 3A.15.1.9 Use of the Electronic Visit Verification system for persons receiving home health, private duty nursing, and/or occupational, physical or speech therapy services (upon implementation of such system in the CHOICES program);
 - 3A.15.1.10 How to immediately identify and address service gaps;

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- 3A.15.1.11 Conducting a home visit and use of the monitoring checklist;
- 3A.15.1.12 Management of critical transitions (including hospital discharge planning);
- 3A.15.1.13 Intellectual disabilities;
- 3A.15.1.14 Physical disabilities;
- 3A.15.1.15 Physical and behavioral health issues common in occurrence and nursing procedures frequently required for persons with intellectual disabilities;
- 3A.15.1.16 Disease management;
- 3A.15.1.17 Identification and management of behavioral health conditions;
- 3A.15.1.18 Evaluation and management of physical and behavioral health risks;
- 3A.15.1.19 Advance directives and end of life care;
- 3A.15.1.20 HIPAA;
- 3A.15.1.21 Cultural competency; and
- 3A.15.1.22 Disaster planning.

3A.15.2 The CONTRACTOR shall establish roles and job responsibilities for Nurse Care Managers. The job responsibilities shall include a description of activities and required timeframes for completion. These activities shall include the requirements specified in this Section.

3A.16 Nurse Care Management Monitoring

3A.16.1 The CONTRACTOR shall develop a comprehensive program for monitoring, on an ongoing basis, the effectiveness of its Nurse Care Management processes. The CONTRACTOR shall immediately remediate all individual findings identified through its monitoring process, and shall also track and trend such findings and remediations to identify systemic issues of poor performance and/or non-compliance, implement strategies to improve care coordination processes and resolve areas of non-compliance, and shall measure the success of such strategies in addressing identified issues. At a minimum, the CONTRACTOR shall ensure that:

- 3A.16.1.1 Needs assessments and reassessment, as applicable, occur on schedule and identify members' physical and behavioral health needs;
- 3A.16.1.2 Integrated Plans of Health Care are developed and updated on schedule and in compliance with this Agreement;
- 3A.16.1.3 Integrated Plans of Health Care reflect physical and behavioral health needs identified in the assessment and reassessment processes;
- 3A.16.1.4 Integrated Plans of Health Care are appropriate and adequate to address members' physical and behavioral health needs;

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- 3A.16.1.5 Services are delivered as specified in the Integrated Plan of Health Care and authorized by the CONTRACTOR;
- 3A.16.1.6 Services are delivered in a timely manner;
- 3A.16.1.7 Service utilization is appropriate;
- 3A.16.1.8 Service gaps are identified and addressed in a timely manner;
- 3A.16.1.9 Minimum Nurse Care Manager contacts are conducted;
- 3A.16.1.10 Nurse Care Manager-to-member ratios are appropriate.

3A.16.2 The CONTRACTOR shall conduct periodic consumer satisfaction surveys of TennCare Select Members in the Arlington Class who are participating in the IHSD model, and shall provide such results to TennCare for review and dissemination.

3A.17 Use of an Electronic Visit Verification System

3A.17.1 Upon the development and implementation of an Electronic Visit Verification (EVV) system under the CHOICES in Long-Term Care Program, the CONTRACTOR shall utilize such system to monitor member receipt and utilization of medically necessary home health, private duty nursing and occupational, physical and speech therapy services covered under the TennCare 1115 Waiver program that are authorized by the CONTRACTOR. The EVV system shall have the following minimal functionality:

- 3A.17.1.1 The ability to log the arrival and departure of individual provider staff person;
- 3A.17.1.2 The ability to verify in accordance with business rules that services are being delivered in the correct location (e.g., the member's residence);
- 3A.17.1.3 The ability to verify the identity of the individual provider staff person providing the service to the member;
- 3A.17.1.4 The ability to match services provided to a member with services authorized in the Integrated Plan of Health Care;
- 3A.17.1.5 The ability to ensure that the provider delivering the service is authorized to deliver such services;
- 3A.17.1.6 The ability to establish a schedule of services for each member which identifies the time at which each service is needed, and the amount, frequency, duration and scope of each service, and to ensure adherence to the established schedule;
- 3A.17.1.7 The ability to provide immediate (i.e., "real time") notification to Nurse Care Managers if a provider does not arrive as scheduled or otherwise deviates from the authorized schedule so that service gaps and the reason the service was not provided as scheduled, are immediately identified and addressed, including through the implementation of back-up plans, as appropriate;
- 3A.17.1.8 The ability for the provider to submit claims to the CONTRACTOR; and

3A.17.1.9 The ability to reconcile paid claims with service authorizations.

3A.17.2 The CONTRACTOR shall monitor and use information from the EVV system to verify that home health, private duty nursing, and occupational, physical and speech therapy services covered under the TennCare 1115 Waiver program are provided as specified in the Integrated Plan of Health Care, and in accordance with the established schedule, including the amount, frequency, duration, and scope of each service, and that services are provided by the authorized provider; and to identify and immediately address service gaps, including late and missed visits. The CONTRACTOR shall monitor services anytime a member is receiving services, including after the CONTRACTOR's regular business hours.

3A.18 Care Management System

3A.18.1 The CONTRACTOR shall develop and maintain an electronic care management system that includes the functionality to ensure compliance with all requirements specified in this Agreement, and in TennCare policies and protocols, including but not limited to the following:

3A.18.1.1 The ability to capture and track key dates and timeframes specified in this Agreement, e.g., as applicable, date of enrollment into TennCare Select and the Integrated Health Services Delivery Model, date of Nurse Care Manager assignment and notification to the member, date of the face-to-face assessment; date of completion of the individualized, Integrated Plan of Health Care; date of authorization and initiation of services specified in the Integrated Plan of Health Care, date of each reassessment, and the date of each update to the Integrated Plan of Health Care;

3A.18.1.2 The ability to capture and track compliance with minimum Nurse Care Manager contacts as specified in this Agreement;

3A.18.1.3 The ability to track and notify the Nurse Care Manager regarding key dates, e.g., date for minimum Nurse Care Manager contacts; date for annual reassessment of needs reassessment;

3A.18.1.4 The ability to capture and track needs assessments and reassessments;

3A.18.1.5 The ability to capture and monitor the Integrated Plan of Health Care;

3A.18.1.6 The ability to track requested and approved service authorizations, including any services provided as a cost-effective alternative to other covered services;

3A.18.1.7 The ability to establish a schedule of home health, private duty nursing and/or occupational, physical or speech therapy services for each member which identifies the time at which each service is needed and the amount, frequency, duration and scope of each service;

3A.18.1.8 The ability to provide, via electronic interface with the EVV system, service authorizations on behalf of the member, including the schedule at which each service is needed;

3A.18.1.9 The ability to track service delivery against authorized services and providers;

3A.18.1.10 The ability to track actions taken by the Nurse Care Manager to immediately address service gaps; and

3A.18.1.11 The ability to document case notes relevant to the provision of care coordination.

3A.19 Transition of Members Currently Receiving Care Through the Community Services Network

3A.19.1 Upon the determination of a schedule for implementation of the Integrated Health Services Delivery Model, TennCare will issue notice to Arlington Class Members currently receiving care through the CSN. The notice shall be sent to the member, and the family or conservator.

3A.19.2 Such notice shall provide sixty (60) days advance notice of the termination of CSN's contracted role in coordinating and managing care for Arlington Class Members. Members will be given thirty (30) days to notify TennCare if they wish to transition from Community Services Network into TennCare Select and to participate in the Integrated Health Services Delivery Model. A form will be enclosed that may be used to provide such notification.

3A.19.3 Upon receipt of notification from a member or the family or conservator, TennCare shall notify the CONTRACTOR of the names, family or conservator names and contact information (as appropriate), and the current residence of Arlington Class Members electing to opt into TennCare Select and to participate in the Integrated Health Services Delivery Model. Such notification shall include the name and contact information for the currently assigned CSN Nurse Care Manager (if made available by CSN), and the name and contact information for the current Independent Support Coordinator or Case Manager (as applicable)—which shall be provided by DIDS. A notification process shall be established with the CONTRACTOR prior to implementation.

3A.19.4 The CONTRACTOR shall, within five (5) business days of such notification by TENNCARE, assign a specific Nurse Care Manager who shall have primary responsibility for performance of Nurse Care Management activities as specified in this Agreement, and who shall be the member's point of contact for coordination of physical and behavioral health services.

3A.19.5 The CONTRACTOR shall, within ten (10) business days of such notification by TENNCARE, provide written notice to the member including the name, phone number, business addresses and email address for his/her assigned Nurse Care Manager, and how to obtain assistance for urgent physical and behavioral health needs after hours. Such notice may be hand-delivered during the first face-to-face visit, if completed within (10) business days.

3A.19.6 The Nurse Care Manager shall contact the currently assigned CSN Nurse Care Manager (if available) and the Independent Support Coordinator or Waiver Case Manager (as applicable) to obtain a copy of the current Individual Support Plan, and to identify current medical, behavioral and long-term care (including HCBS) services the member is receiving, as well as providers of such services.

3A.19.7 The Nurse Care Manager shall request and review available medical records, and shall contact existing physical and behavioral health and long-term care providers as needed to help guide and inform the assessment and transition processes.

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- 3A.19.8 As part of the transition process, the assigned Nurse Care Manager shall utilize such contacts and medical information to help identify members currently receiving barbiturates and benzodiazepines through CSN. (The State shall also seek to obtain such information directly from CSN.) If a member is currently receiving barbiturates and benzodiazepines through CSN, the Nurse Care Manager shall contact the prescribing physician to help facilitate transition to covered medications prior to the member's transition to the Integrated Health Services Delivery Model.
- 3A.19.9 Also as part of the transition process, the assigned Nurse Care Manager shall utilize such contacts and medical information to identify any service that an Arlington Class member was receiving through CSN that is not a covered benefit under either TennCare Select or the Arlington waiver and when appropriate, will work with the MCO or the waiver to attempt to transition such Class member to an appropriate covered service. The CONTRACTOR shall provide to TennCare for review and dissemination quarterly reports on such non-covered services beginning one quarter after CSN members begin transitioning from CSN to the IHSD model and continuing for one year after all Arlington Class members have been transitioned from CSN.
- 3A.19.10 The Nurse Care Manager shall schedule a face-to-face visit with the member and family or conservator to provide an introduction to the Integrated Health Services Delivery Model and to complete the face-to-face assessment.
- 3A.19.11 For members transitioning from CSN to the Integrated Health Services Delivery Model, the CONTRACTOR shall include in the Integrated Plan of Health Care identification of all transition of care issues and concerns, including specific actions that will be taken to address such issues and concerns, and to ensure a seamless transition of care.
- 3A.19.12 Upon transition to the Integrated Health Services Delivery Model, the CONTRACTOR shall continue providing all covered physical and behavioral health services in accordance with the plan of care in place authorized by CSN for a period of at least thirty (30) calendar days, without regard to whether such services are being provided by contract or non-contract providers. Reimbursement for such services shall be provided in accordance with established in-network rates. Such period shall be extended as necessary to ensure seamless transition to the newly developed Integrated Plan of Health Care.
- 3A.19.13 Members not electing to transition to TennCare Select will remain enrolled with their current MCO and will begin receiving covered physical and behavioral health services through their assigned MCO. Nurse Care Management shall be available only to Arlington Class Members opting to enroll in TennCare Select.
- 3A.20 Coordination with Long-Term Care Services**
- 3A.20.1 The CONTRACTOR shall provide ongoing coordination with long-term care services the member receives, including Home and Community Based Services (HCBS) provided under a Section 1915(c) waiver program for persons with intellectual disabilities (i.e., mental retardation) or Institutional services in an Intermediate Care Facility for persons with Mental Retardation (ICF/MR) or Nursing Facility, as applicable; and continuous collaboration between the member's care providers and payors, including TennCare, DIDS, and the CONTRACTOR who will be responsible for the coordination, delivery and payment of all medically necessary covered physical and behavioral health services.

Amendment Number 21 (cont.)

- 3A.20.2 Each member's Nurse Care Manager shall participate in the Individual Support Plan development process as needed to ensure the identification of physical and/or behavioral health needs and to facilitate timely access to covered physical and/or behavioral health services.
- 3A.20.3 The Nurse Care Manager shall be the single point of contact for coordinating the member's physical and behavioral health needs, even when such care may be provided as an Extended State Plan benefit under one of the State's Section 1915(c) Waiver programs for persons with intellectual disabilities (i.e., mental retardation).
- 3A.20.4 TennCare and DIDS shall provide training for Nurse Care Managers regarding covered HCBS Waiver benefits, including specific delineation of services covered under the TennCare 1115 Waiver (i.e., Medicaid State Plan), and services covered under the MR Waiver programs. If a service needed by an MR Waiver participant is not covered under the TennCare 1115 Waiver Program, but is instead covered under the MR Waiver program in which the member is enrolled, the Nurse Care Manager shall be responsible for coordinating with the Independent Support Coordinator (ISC) or Waiver Case Manager (WCM), as applicable, to address the member's need. Such responsibility shall not be satisfactorily met by means of redirecting the member or guardian/conservator to the ISC or WCM, or even by referral to the ISC or WCM. The Nurse Care Manager shall coordinate with the ISC or WCM to ensure that the physical or behavioral health need is timely addressed.
- 3A.21 TennCare Select Provider Network**
- 3A.21.1 The CONTRACTOR shall utilize the TennCare Select provider network to deliver services to participants in the Integrated Health Services Delivery Model.
- 3A.21.2 The CONTRACTOR shall recruit and contract with an adequate number of providers to meet the needs of all TennCare Select Members (as set forth in this Agreement), including participants in the Integrated Health Services Delivery Model.
- 3A.21.3 The CONTRACTOR's network must have adequate capacity to deliver covered physical and behavioral health services that meet the needs of persons with I/DD. Indicators of an adequate network include, but are not limited to:
- 3A.21.3.1 The CONTRACTOR meets guidelines established in this Agreement for a provider network.
 - 3A.21.3.2 The CONTRACTOR has sufficient types and numbers of providers to be able to consistently deliver services in a timely manner; and
 - 3A.21.3.3 The CONTRACTOR has within its network specialized health providers with sufficient expertise to deliver covered physical and behavioral health needed by persons with I/DD.
- 3A.21.4 The CONTRACTOR shall, within the TennCare Select network, identify and/or recruit and contract with physical and behavioral health care providers, in particular PCPs, who have the qualifications, capabilities and resources to work with persons with I/DD.
- 3A.21.5 Such PCPs shall be identified as providers in a special primary care network for TennCare Select members in the Integrated Health Services Delivery Model that is modeled on the TennCare Select BPN network for children in state custody; however, members of the Integrated Health

Services Delivery Model shall be permitted to utilize TennCare Select Network providers outside the special primary care network.

- 3A.21.6 The CONTRACTOR shall make its best efforts to recruit and include in the TennCare Select Network of service providers, the active CSN PCPs and the active CSN specialty service providers (i.e., providers that have delivered covered services to CSN members within the last twelve (12) months), provided that such providers satisfy credentialing requirements. The CONTRACTOR shall provide to TennCare for review and dissemination quarterly reports on its efforts to recruit CSN providers beginning one quarter after approval of the federal court to replace CSN with the IHSD model, and continuing for one year after all Arlington Class members have been transitioned from CSN.
- 3A.21.7 The CONTRACTOR is permitted to offer PCPs an additional per member per month fee if necessary to recruit the requisite number of providers and cause them to undertake the responsibilities associated with caring for members of the Integrated Health Services Delivery Model. These responsibilities will be reflected in the provider agreement between the CONTRACTOR and any PCP who is offered and accepts the additional per member per month fee.
- 3A.21.8 The CONTRACTOR shall develop policies and procedures for assigning participants in the Integrated Health Services Delivery Model to PCPs with I/DD expertise.
- 3A.21.9 The CONTRACTOR shall implement, distribute and train and monitor PCPs and specialists regarding the use of best practice guidelines for acute and chronic conditions common to persons with I/DD.
- 3A.21.10 The CONTRACTOR shall provide training opportunities for PCPs and other providers regarding the unique needs of persons with I/DD, how to improve the quality of service delivery, and effective collaboration with family members and conservators.

4. Section 4.1 shall be deleted and replaced as follows:

4.1 Administrative Fee

- 4.1.1 The CONTRACTOR shall be paid a fixed fee per member per month for specified Eligible Groups for the administration of TennCare Select according to the requirements of this Agreement. The administrative fee to be paid for each specified Eligible Group shall be described in Attachment XVI of this Agreement.
- 4.1.2 TennCare or its appointed agent shall make payment by the fifth working day of each month to the CONTRACTOR for the CONTRACTOR's satisfactory performance of its duties and responsibilities as set forth in this Agreement. Each month payment to the CONTRACTOR shall be equal to the number of enrollees certified by TENNCARE multiplied by the administrative fee for the appropriate enrollee category. The actual amount owed the CONTRACTOR for each enrollee shall be determined by dividing the appropriate monthly administrative fee by the number of days in the month and then multiplying the quotient of this transaction by the actual number of days the enrollee was enrolled in the plan.
- 4.1.3 Payment for enrollees shall start the effective date of the enrollee's enrollment in the plan.
- 4.1.4 The CONTRACTOR agrees the State may retroactively recoup Administrative Fee payments for deceased enrollees. Retroactive recoupment will be deducted from the monthly payment for the following month. Payments may be recouped back to the date of death. This is the only provision whereby the State

Amendment Number 21 (cont.)

may retroactively recoup administrative fee payments from the CONTRACTOR for enrollees retroactively terminated from TennCare Select.

4.1.5 Administrative fee payments made in accordance with Section 4.1.1, 4.1.2, and Attachment XVI will not include payment for children in state custody for whom Immediate Eligibility was established and who were not subsequently found to be TennCare eligible. TennCare shall make a separate payment for said children upon receipt of an invoice from the CONTRACTOR. The invoice shall be submitted to TENNCARE in the form and format specified in Attachment XIII, Exhibit N on a monthly basis. The administrative fee due shall be equal to the number of enrollees for whom Immediate Eligibility was established multiplied by a flat rate equal to the per member per month for Group 1.A, for the full 45 day eligibility period.

4.1.6 As described herein, administrative fee payments made in accordance with Section 4.1.1, 4.1.2, and Attachment XVI will not include payment for enrollees specified in Group 5^{IHSDM}, Persons with Intellectual Disabilities who have been defined as the Target Population for the Integrated Health Services Delivery Model described in Section 3A of this Agreement. For enrollees in Group 5^{IHSDM}, TENNCARE shall reimburse the CONTRACTOR for actual and reasonable cost associated with the management and delivery of covered services to this population based on an invoice submitted by the CONTRACTOR.

4. Section 4.6.1 shall be deleted and replaced as follows:

4.6.1 In no event shall the maximum liability of the State under this Agreement during the original term of the Agreement exceed One Billion, Three Hundred Eighty Two Million, Six Hundred Eighty Three Thousand, Nine Hundred Five Dollars and Ninety Cents (\$1,382,683,905.90).

5. Attachment XVI shall be amended by adding a new item V which shall read as follows:

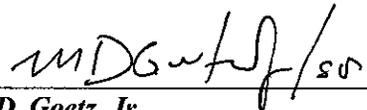
V. Administrative Fee Effective Upon Implementation of the Integrated Health Services Delivery Model

Enrollee Category	Effective Upon Implementation of the Integrated Health Services Delivery Model
Group 1.A	\$29.00 PMPM
Group 1.B	\$29.00 PMPM
Group 2	\$29.00 PMPM
Group 3	\$29.00 PMPM
Group 4	\$29.00 PMPM
Group 5^{IHSDM}	TennCare shall reimburse actual and reasonable costs associated with the management and delivery of covered services for this population as specified in Section 4.1.6.
Group 5	\$29.00 PMPM
Group 6	\$29.00 PMPM

All of the provisions of the original Agreement not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective January 1, 2010.

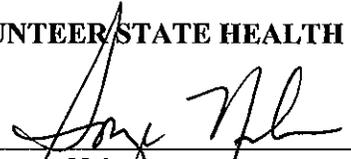
IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION
BUREAU OF TENNCARE**

BY: 
*M. D. Goetz, Jr.
Commissioner*

DATE: 12/15/09

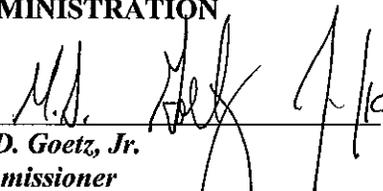
VOLUNTEER STATE HEALTH PLAN, INC.

BY: 
*Sonya Nelson
President and Chief Executive Officer*

DATE: 12/09/09

APPROVED BY:

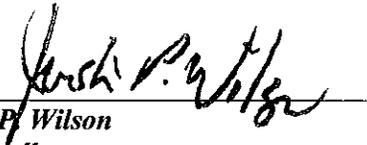
**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

BY: 
*M. D. Goetz, Jr.
Commissioner*

DATE: 12/21/09

APPROVED BY:

**STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY**

BY: 
*Justin P. Wilson
Comptroller*

DATE: 01/05/10

CONTRACT SUMMARY SHEET

RFS Number:	318.66-026	Contract Number:	FA-02-14632-20
State Agency:	Department of Finance and Administration	Division:	Bureau of TennCare

Contractor	Contract Identification Number
VSHP (TennCare Select)	<input type="checkbox"/> V- <input type="checkbox"/> C-

Service Description

Managed Care Organization / Medically Necessary Health Care Services to the TennCare

Contract Begin Date	Contract End Date
7/1/2001	6/30/2010

Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66	4A2	134	11	<input type="checkbox"/> STARS		
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)	
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$ 18,599,868.48	
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$ 33,079,942.80	
2004	\$ 25,125,990.72	\$ 38,364,165.90			\$ 63,490,156.62	
2005	\$ 58,007,447.00	\$ 58,007,447.00			\$ 116,014,894.00	
2006	\$87,748,111.00	\$87,748,111.00			\$175,496,222.00	
2007	\$87,748,111.00	\$87,748,111.00			\$175,496,222.00	
2008	\$72,610,000.00	\$127,390,000.00			\$200,000,000.00	
2009	\$72,610,000.00	\$127,390,000.00			\$200,000,000.00	
2010	\$99,077,418.00	\$284,052,582.00			\$383,130,000.00	
Total:	\$ 525,468,138.35	\$ 839,839,167.55			\$1,365,307,305.90	

OCT 10 2009
 JUL 10 2009
 TO ACCOUNTS

CFDA#	93.778 Title XIX Dept. of Health & Human Svcs.	Check the box ONLY if the answer is YES:
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State Fiscal Contract		
Name:	Scott Pierce	Is the Contractor a SUBRECIPIENT? (per OMB A-133)
Address:	310 Great Circle Road	Is the Contractor a Vendor? (per OMB A-133)
Phone:	Nashville, TN (615)507-6415	Is the Fiscal Year Funding STRICTLY LIMITED?
Procuring Agency Budget Officer Approval Signature		Is the Contractor on STARS?
Scott Pierce <i>[Signature]</i>		Is the Contractor's FORM W-9 ATTACHED?
		Is the Contractor's Form W-9 Filed with Accounts?

COMPLETE FOR ALL AMENDMENTS (only)			Funding Certification
CONTRACT END DATE:	Base Contract & Prior Amendments	This Amendment ONLY	Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.
	6/30/2009	6/30/2010	
FY: 2002	\$ 18,599,868.48		
FY: 2003	\$ 33,079,942.80		
FY: 2004	\$ 63,490,156.62		
FY: 2005	\$116,014,894.00		
FY: 2006	\$175,496,222.00		
FY: 2007	\$175,151,878.00		
FY: 2008	\$200,000,000.00		
FY: 2009	\$200,000,000.00		
FY: 2010			
Total:	\$982,177,305.90	\$383,130,000.00	

2009 JUL 10 AM 11:31
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 DIV OF ACCOUNTS
 TENNESSEE

OCR
 JUN 30 2009
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AMENDMENT NUMBER 20

**AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.**

CONTRACT NUMBER: FA-02-14632-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as follows:

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

Item 13 shall become effective July 1, 2009. All other Items described below shall become effective September 1, 2009 unless otherwise specified.

- 1. The Section/Sub-section numbering format shall be amended by deleting and replacing dashes (-) with periods (.) and changing the lettering in subsections to numbering so that the Section/Sub-section formatting shall be “1.1.1.1”, etc.**
- 2. References to medical services as covered services under this contract shall be amended by adding a reference to “behavioral health” services where appropriate to indicate the full scope of services covered by this contract.**
- 3. Section 1, Definitions, shall be amended by deleting the definition “Behavioral Health Organization (BHO)”, adding the following new definitions and deleting and replacing the following existing definitions:**

Administrative Cost - All costs to the Contractor related to the administration of this Agreement that are non-medical in nature, including, but not limited to:

- Satisfying Contractor Qualifications specified in Sections 2.1 and 2.2
- Enrollment and Disenrollment in accordance with Section 2.4 and 2.5;
- Additional services and use of incentives in Section 2.6.7;
- Management of Medical Care and Coordination of Care policies and procedures established in accordance with Section 2.9 with the exception of Medical Case Management;
- Establishing and Maintaining a Provider Network in accordance with the Access and Availability requirements specified in Section 2.11, Attachment III, Attachment IV, and Attachment V;
- Utilization Management policies and procedures, including prior authorization policies and procedures established in accordance with Section 2.14;
- Quality Assurance and Improvement activities as specified in Section 2.15;
- Quality Monitoring/Quality Improvement Program established in accordance with Section 2.15;
- Production and distribution of Marketing and Enrollee Materials as specified in Section 2.17;
- Customer service requirements in Section 2.18;
- Appeals processing and resolution in accordance with Section 2.19;
- Determination of recoveries from Third Party Liability resources in accordance with Section 2.21.4;
- Claims Processing in accordance with 2.22;
- Referral and Exemption Requirements established in accordance with this Agreement;
- Out of Area or Out of Plan Use policies and procedures established in accordance with this Agreement;
- Transplant policies and procedures established in accordance with Section 2.6;

Amendment Number 20 (cont.)

- Prenatal Care policies and procedures established in accordance with this Agreement;
- Maintenance and operation of Information Systems in accordance with Section 2.23;
- Personnel requirements in Section 2.29
- Production and submission of required reports as specified in Section 2.30;
- Administration of this Agreement in accordance with Medical Management Policies and Procedures;
- All other Administration and Management responsibilities as specified in Attachments II through IX and Sections 2.20, 2.21, 2.24, 2.25, 2.26, 2.27, and 2.28;
- Premium tax, and
- All costs related to third party recovery or subrogation activities whether performed by the Contractor or a subcontractor.

Costs of subcontractors engaged solely to perform a non-medical administrative function for the CONTRACTOR specifically related to securing or fulfilling the CONTRACTOR's obligations to TENNCARE under the terms of this Agreement (e.g., claims processing, marketing) are considered to be an "administrative cost".

Behavioral Health Assessment – Procedures used to diagnose mental health or substance abuse conditions and determine treatment plans.

Behavioral Health Services – Mental health and/or substance abuse services.

Benefits – A schedule of health care services, including behavioral health services, that define the covered services available to TennCare enrollees enrolled in the CONTRACTOR's MCO pursuant to this Agreement.

Behavioral Health Services – Mental health and/or substance abuse services.

Centers of Excellence (COE) for Behavioral Health – COEs that provide a limited range of direct services to children in and at risk for state custody (i.e., not just DCS children/youth). These services are to augment the existing service system. Therefore, COEs for Behavioral Health typically only provide services where there is sufficient complexity in the case to warrant the COE for Behavioral Health resources and/or all other means to provide the service in the TennCare network have been exhausted.

Clinically Related Group 1: Severely and/or Persistently Mentally Ill (SPMI) – Persons in this group are 18 years or older with a valid DSM-IV-TR (and subsequent revisions) diagnosis excluding substance use disorders, developmental disorders or V-codes. They are recently severely impaired and the duration of their severe impairment totals six months or longer of the past year.

Clinically Related Group 2: Persons with Severe Mental Illness (SMI) – Persons in this group are 18 years or older with a valid DSM-IV-TR (and subsequent revisions) diagnosis excluding substance use disorders, developmental disorders or V-codes. Persons in this group are recently severely impaired and the duration of their severe impairment totals less than six months of the past year.

Clinically Related Group 3: Persons who are Formerly Severely Impaired – Persons in this group are 18 years or older with a valid DSM-IV-TR (and subsequent revisions) diagnosis excluding substance use disorders, developmental disorders or V-codes. Persons in this group are not recently severely impaired but have been severely impaired in the past and need services to prevent relapse.

Clinically Related Group 4: Persons with Mild or Moderate Mental Disorders – Persons in this group are 18 years or older with a valid DSM-IV-TR (and subsequent revisions) diagnosis excluding substance use disorders, developmental disorders or V-codes. Persons in this group are not recently severely impaired and are *either* not formerly severely impaired *or* are formerly severely impaired but do not need services to prevent relapse.

Clinically Related Group 5: Persons who are not in clinically related groups 1-4 as a result of their diagnosis – Persons in this group are 18 years or older diagnosed with DSM-IV-TR (and subsequent revisions) substance use disorders, developmental disorders or V-codes only.

Consumer – An individual who uses a mental health or substance abuse service.

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CRG (Clinically Related Group) – Defining and classifying consumers 18 years or older into clinically related groups involves diagnosis, the severity of functional impairment, the duration of severe functional impairment, and the need for services to prevent relapse. Based on these criteria, there are five clinically related groups:

Group 1 - Persons with Severe and Persistent Mental Illness (SPMI)

Group 2 - Persons with Severe Mental Illness (SMI)

Group 3 - Persons who were Formerly Severely Impaired and need services to prevent relapse

Group 4 - Persons with Mild or Moderate Mental Disorder

Group 5 - Persons who are not in Clinically Related Groups 1 – 4 as a result of their diagnosis being substance use disorder, developmental disorder, or V-codes

Days – Calendar days unless otherwise specified.

Emergency Medical Condition - A medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Evidence-Based Practice – A clinical intervention that has demonstrated positive outcomes in several research studies to assist consumers in achieving their desired goals of health and wellness; specifically, the evidence-based practices recognized by the Substance Abuse and Mental Health Services Administration’s (SAMHSA) Center for Mental Health Services (CMHS).

Grand Region – A defined geographical region that includes specified counties in which the CONTRACTOR is authorized to enroll and serve TennCare enrollees in exchange for a monthly administrative fee payment. The CONTRACTOR shall serve an entire Grand Region. The following counties constitute the Grand Regions in Tennessee:

East Grand Region – Anderson, Bledsoe, Blount, Bradley, Campbell, Carter, Claiborne, Cocke, Franklin, Grainger, Greene, Grundy, Hamblen, Hamilton, Hancock, Hawkins, Jefferson, Johnson, Knox, Loudon, Marion, McMinn, Meigs, Monroe, Morgan, Polk, Rhea, Roane, Scott, Sequatchie, Sevier, Sullivan, Unicoi, Union, and Washington Counties

Middle Grand Region – Bedford, Cannon, Cheatham, Clay, Coffee, Cumberland, Davidson, DeKalb, Dickson, Fentress, Giles, Hickman, Houston, Humphreys, Jackson, Lawrence, Lewis, Lincoln, Macon, Marshall, Maury, Montgomery, Moore, Overton, Perry, Pickett, Putnam, Robertson, Rutherford, Smith, Stewart, Sumner, Trousdale, Van Buren, Warren, Wayne, White, Williamson, and Wilson Counties

West Grand Region – Benton, Carroll, Chester, Crockett, Decatur, Dyer, Fayette, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Lake, Lauderdale, Madison, McNairy, Obion, Shelby, Tipton, and Weakley Counties

Healthcare Effectiveness Data and Information Set (HEDIS) – The most widely used set of standardized performance measures used in the managed care industry, designed to allow reliable comparison of the performance of managed health care plans. HEDIS is sponsored, supported, and maintained by the National Committee for Quality Assurance.

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Legally Appointed Representative – Any person appointed by a court of competent jurisdiction or authorized by legal process (e.g., power of attorney for health care treatment, declaration for mental health treatment) to determine the legal and/or health care interests of an individual and/or his/her estate.

Mandatory Outpatient Treatment (MOT) – Process whereby a person who was hospitalized for psychiatric reasons and who requires outpatient treatment can be required by a court to participate in that behavioral health outpatient treatment to prevent deterioration in his/her mental condition.

Medical Expenses (sometimes referred to as “Covered Services”) - Consist of the following:

- a. The cost of providing TennCare Program medical and/or behavioral services to enrollees as identified below and pursuant to the following listed Sections of the Agreement:
 1. 2.6.1 Covered Benefits
 2. 2.9.8 Coordination of Dental Services
 3. 2.6.7 Use of Cost Effective Alternative Services
 4. 2.6.9 Coverage of Sterilization’s, Abortions and Hysterectomies pursuant to applicable federal and state laws and regulations
 5. 2.6.10 Coverage of Organ and Tissue Transplants
 6. all services related to hospice
 7. capitated payment to licensed health care providers
 8. medical services directed by TENNCARE or an Administrative Law Judge
 9. net impact of reinsurance coverage purchased by the MCO
- b. Preventive Services: In order for preventive services in Section 2.6 (including, but not limited to, health education, medical case management and health promotion activities) to qualify as medical expenses, the service must be targeted to and limited to the CONTRACTOR’s enrollees or targeted to meet the enrollee’s individual needs and the allocation methodology for capturing said costs must be approved by TENNCARE.
- c. Medical case management may qualify as medical expenses if the service is targeted to meet the enrollee’s individual needs and the allocation methodology for capturing said costs is approved by TENNCARE.
- d. Medical Expenses do not include:
 1. 2.10 Services Not Covered;
 2. 2.9.10 Institutional Services and Alternatives to Institutional Services;
 3. Services eligible for reimbursement by Medicare;
 4. The activities described in or required to be conducted in Attachments II, III, IV, V, X, XI, XII, XIII, XV (including, but not limited to, utilization management, utilization review activities) are administrative costs; and
 5. The two percent HMO tax.
- e. Medical expense will be net of any TPL recoveries or subrogation activities..
- f. This definition does not apply to NAIC filings.

Medical Records - All medical and behavioral health histories; records, reports and summaries; diagnoses; prognoses; records of treatment and medication ordered and given; X-ray and radiology interpretations; physical therapy charts and notes; lab reports; other individualized medical and behavioral health documentation in written or electronic format; and analyses of such information.

Primary Care Provider - A primary care physician or or other licensed health practitioner practicing in accordance with state law who is responsible for providing preventive and primary health care to patients;; for initiating referrals for specialist care; and for maintaining the continuity of patient care. A PCP may practice in various settings such as local health departments, FQHCs or community mental health agencies (CMHAs) provided that the PCP is willing and able to carry out all PCP responsibilities in accordance with this Agreement.

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Priority Enrollee – A TennCare enrollee who has been assessed within the past twelve (12) months as belonging in Clinically Related Groups (CRGs) 1, 2, or 3 if he/she is 18 years old or older, or Target Population Group (TPG) 2 if he/she is under the age of 18 years. This assessment as a Priority enrollee expires twelve (12) months after the assessment as been completed. In order for an individual to remain a Priority enrollee after the twelve (12) month period ends, he/she must be reassessed as continuing to meet the criteria to belong in CRGs 1, 2, or 3 or TPG 2 categories. The reassessment, like the initial assessment, expires after twelve (12) months unless another assessment is done. Also referred to as Priority member once the enrollee is enrolled in the CONTRACTOR's MCO.

Quality Management (QM) – The ongoing process of assuring that the delivery of covered services is appropriate, timely, accessible, available, and medically necessary and in keeping with established guidelines and standards and reflective of the current state of medical and behavioral health knowledge.

Recovery – A consumer driven process in which consumers are able to work, learn and participate fully in their communities. Recovery is the ability to live a fulfilling and productive life despite a disability.

Resilience – A dynamic developmental process for children and adolescents that encompasses positive adaptation and is manifested by traits of self-efficacy, high self-esteem, maintenance of hope and optimism within the context of significant adversity.

Routine Care – Non urgent and non-emergency medical or behavioral health care such as screenings, immunizations, or health assessments.

Seriously Emotionally Disturbed (SED) – Seriously Emotionally Disturbed shall mean persons who have been identified by the Tennessee Department of Mental Health and Developmental Disabilities or its designee as meeting the criteria provided below:

Person under the age of 18; and

Currently, or at any time during the past year, has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV-TR (and subsequent revisions) of the American Psychiatric Association with the exception of DSM-IV-TR (and subsequent revisions) V- codes, substance use, and developmental disorders, unless these disorders co-occur with another diagnosable mental, behavioral, or emotional disturbance other than above exclusions. All of these disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity and disabling effects; and

The diagnosable mental, behavioral, or emotional disorder identified above has resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, and community activities. Functional impairment is defined as difficulties that substantially interfere with or limit a child or adolescent in achieving or maintaining developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills and is evidenced by a Global Assessment of Functioning (GAF) score of 50 or less in accordance with the DSM-IV-TR (and subsequent revisions). Children and adolescents who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition.

Severely and/or Persistently Mentally Ill (SPMI) – Severely and/or Persistently Mentally Ill shall mean individuals who have been identified by the Tennessee Department of Mental Health and Developmental Disabilities or its designee as meeting the following criteria. These persons will be identified as belonging in one of the Clinically Related Groups that follow the criteria:

Age 18 and over; and

Currently, or at any time during the past year, has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified within DSM-IV-TR (and subsequent revisions) of the American Psychiatric Association, with the exception of DSM-IV-TR (and subsequent revisions) V-codes, substance use disorders, and developmental disorders, unless these disorders co-occur with another diagnosable serious mental illness other than above exclusions. All of these disorders have episodic, recurrent, or persistent features, however, they vary in terms of severity and disabling effects; and

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The diagnosable mental, behavioral, or emotional disorder identified above has resulted in functional impairment which substantially interferes with or limits major life activities. Functional impairment is defined as difficulties that substantially interfere with or limit role functioning in major life activities including basic living skills (e.g., eating, bathing, dressing); instrumental living skills (maintaining a household, managing money, getting around in the community, taking prescribed medication); and functioning in social, family, and vocational/educational contexts. This definition includes adults who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services.

Substance Abuse Services – The assessment, diagnosis, treatment, detoxification, residential care, rehabilitation, education, training, counseling, referral or supervision of individuals who are abusing or have abused substances.

Target Population Group (TPG) – An assessment mechanism for children and adolescents under the age of 18 to determine an individual's level of functioning and severity of impairment due to a mental illness. Based on these criteria, there are three target population groups.

1. Target Population Group 2: Seriously Emotionally Disturbed (SED)
Children and adolescents under 18 years of age with a valid DSM-IV-TR (and subsequent revisions) diagnosis excluding substance use disorders, developmental disorders or V-codes. These children are currently severely impaired as evidenced by 50 or less Global Assessment of Functioning (GAF).
2. Target Population Group 3: At Risk of a (SED)
Children and adolescents under 18 years of age without a valid DSM-IV-TR (and subsequent revisions) diagnosis excluding substance use disorders, developmental disorders or V-codes. These children may or may not be currently seriously impaired as evidenced by Global Assessment of Functioning (GAF). These children have psychosocial issues that can potentially place them at risk of a SED.
3. Target Population Group 4: Persons who do not meet criteria TPG Group 2 or 3
Children and adolescents under 18 years of age without a valid DSM-IV-TR (and subsequent revisions) diagnosis and are not currently seriously impaired as evidenced by Global Assessment of Functioning (GAF). These children have no psychosocial issues that can potentially place them at risk of a SED.

Third Party Liability – Any amount due for all or part of the cost of medical or behavioral health care from a third party.

4. **Existing Sections 2-1 and 2-2 and Section 4 shall be deleted and replaced by new Sections 2.1 through 2.5 as described below. The remaining Sections shall be renumbered accordingly as well as any references thereto.**

2.1 GENERAL REQUIREMENTS

- 2.1.1 The CONTRACTOR shall maintain a standard certificate of authority (COA) from TDCI to operate as an HMO in Tennessee in the service area covered by this Agreement. If the CONTRACTOR subcontracts for the provision of behavioral health services, and that subcontractor accepts risk, TDCI may require that the subcontractor be licensed as a Prepaid Limited Health Service Organization (PLHSO). The CONTRACTOR shall ensure that the CONTRACTOR and its staff, all subcontractors and staff, and all providers and staff retain at all times during the period of this Agreement a valid license, as appropriate, and comply with all applicable licensure requirements.

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- 2.1.2 The CONTRACTOR shall comply with all the provisions of this Agreement and any amendments thereto and shall act in good faith in the performance of these provisions. The CONTRACTOR shall respect the legal rights (including rights conferred by the Agreement) of every enrollee, regardless of the enrollee's family status as head of household, dependent, or otherwise. Nothing in this Agreement may be construed to limit the rights or remedies of enrollees under state or federal law. The CONTRACTOR acknowledges that failure to comply with provisions of this Agreement may result in the assessment of liquidated damages and/or termination of the Agreement in whole or in part, and/or imposition of other sanctions as set forth in this Agreement.
- 2.1.3 The CONTRACTOR shall be responsible for the administration and management of all aspects of this Agreement including all subcontractors, providers, employees, agents, and anyone acting for or on behalf of the CONTRACTOR.
- 2.1.4 Demonstrate sufficient network capability and a willingness, when so directed by TENNCARE, to accept a reasonable number of enrollees enrolled, or requesting enrollment, in any health plan operating in the same community as the CONTRACTOR, including any plan which fails, is terminated in whole or in part, becomes unable to take new enrollees, maintain existing enrollment or discontinues service in the area for any reason. Notwithstanding any provision herein to the contrary, the State reserves the right to transfer enrollee members based upon the demonstrated capacity of the CONTRACTOR, when the State determines that it is in the best interests of the TENNCARE program.

2.2 Requirements for Children in State Custody

- 2.2.1 The CONTRACTOR shall develop and maintain a Best Practice Network of providers with the appropriate expertise and experience and willingness in the special health care needs of children in state custody.
- 2.2.2 The CONTRACTOR hereby agrees to serve as the designated carve-out MCO for the purpose of meeting the needs of children in state custody and agrees to satisfy all special requirements for the delivery of services to children in state custody. The CONTRACTOR further agrees that at such time that any plan for children in State custody is provided and/or approved by the court, the CONTRACTOR shall administer this Agreement in accordance with the requirements of the court order. In the event that TENNCARE makes a determination that the requirements of the court order differ materially from the requirements specified in this Agreement, TENNCARE and the CONTRACTOR agree to negotiate the required amendments to this Agreement for the purpose of incorporating the requirements of the court order. TENNCARE and the CONTRACTOR recognize and agree that said amendment shall reflect mutually agreed upon additional costs to the CONTRACTOR, if any, related to the requirements of the court order, which must be documented by the CONTRACTOR and approved by TENNCARE, for which TENNCARE will compensate the CONTRACTOR.

2.3 ELIGIBILITY

2.3.1 Overview

TennCare is Tennessee's Medicaid program operating under the authority of a research and demonstration project approved by the federal government pursuant to Section 1115 of the Social Security Act. Eligibility for TennCare is determined by the State in accordance with federal requirements and state law and policy.

2.3.2 Eligibility Categories

TennCare currently consists of traditional Medicaid coverage groups (TennCare Medicaid) and an expanded population (TennCare Standard).

2.3.2.1 TennCare Medicaid

As provided in state rules and regulations, TennCare Medicaid covers all Medicaid mandatory eligibility groups as well as various optional categorically needy and medically needy groups, including children, pregnant women, the aged, and individuals with disabilities. Additional detail about eligibility criteria for covered groups is provided in state rules and regulations.

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2.3.2.2 TennCare Standard

TennCare Standard includes the Standard Spend Down (SSD) population as well as an expanded population of children. Additional detail about eligibility criteria for covered groups is provided in state rules and regulations.

2.3.3 **TennCare Applications**

The CONTRACTOR shall not cause applications for TennCare to be submitted.

2.3.4 **Eligibility Determination and Determination of Cost Sharing**

The State shall have sole responsibility for determining the eligibility of an individual for TennCare. The State shall have sole responsibility for determining the applicability of TennCare cost sharing amounts and for the collection of applicable premiums.

2.3.5 **Eligibility for Enrollment in an MCO**

Except for TennCare enrollees enrolled in the Program of All-Inclusive Care for the Elderly (PACE) and enrollees who are only receiving assistance with Medicare cost sharing, all TennCare enrollees will be enrolled in an MCO, including TennCare Select (see definition in Section 1 of this Agreement).

2.4 ENROLLMENT

2.4.1 **General**

TENNCARE is solely responsible for enrollment of TennCare enrollees in an MCO. The TennCare Bureau has identified groups of enrollees who may become members of TennCare Select. TennCare enrollees cannot request to enroll in TennCare Select. Eligibility determination and enrollment of TennCare eligible enrollees in the Contractor's plan shall be the sole responsibility of TENNCARE. For purposes of this Agreement, TENNCARE may define enrollees in specified categories for purposes of payments to the CONTRACTOR and/or enrollee eligibility for specified levels of services and benefits as well as cost share responsibilities.

2.4.2 **Authorized Service Area**

2.4.2.1 Grand Region

Enrollees will be enrolled in MCOs by Grand Region(s) of the state. The specific counties in each Grand Region are listed in Section 1 of this Agreement.

2.4.2.2 CONTRACTOR's Authorized Service Area

In addition to enrollees described in Group 5, the CONTRACTOR is authorized under this Agreement to serve enrollees who reside in the Grand Region(s) specified below:

_X_East Grand Region _X_Middle Grand Region _X_West Grand Region

2.4.3 **Maximum Enrollment**

2.4.3.1 The CONTRACTOR shall maintain sufficient capacity to provide services in accordance with the requirements of this Agreement for up to 300,000 enrollees or the actual number of enrollees enrolled, whichever is greater. This provision is not intended to guarantee enrollment of 300,000 enrollees, nor limit enrollment to 300,000 enrollees. Rather, it is intended to demonstrate the CONTRACTOR's ability and readiness to serve as back-up health plan in the event of a failure of a risk MCO, including any plan which is terminated in whole or in part, becomes unable to take new enrollees, maintain existing enrollment or discontinues service in the area for any reason. Notwithstanding any provision herein to the contrary, the State reserves the right to transfer enrollee members based upon the

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demonstrated capacity of the CONTRACTOR, when the State determines that it is in the best interests of the TENNCARE program.

2.4.4 **Enrollment Criteria for TennCare Select**

2.4.4.1 General

TENNCARE shall enroll the following individuals determined eligible for TennCare and eligible for enrollment in an MCO under the authority of a 1915(b) waiver to be enrolled in TennCare Select.

2.4.4.1.1 *Eligible Groups*

2.4.4.1.1.1 **Group 1.A:** Children who are in DCS custody;

2.4.4.1.1.2 **Group 1.B:** Children who are transitioning out of DCS custody;

2.4.4.1.1.3 **Group 2:** Children under 21 who are SSI eligible;

2.4.4.1.1.4 **Group 3:** Children receiving services in an institution or as part of the State's Home and Community Based Service waiver in order to avoid being institutionalized;

2.4.4.1.1.5 **Group 4:** Enrollees residing out-of-state;

2.4.4.1.1.6 **Group 5:** Enrollees that have not responded to TennCare's attempts to contact and/or enrollees that are in specified Groups/Populations defined and identified by the State and agreed to by both parties; and

2.4.4.1.1.7 **Group 6:** Enrollees residing in areas with insufficient capacity in other TennCare MCOs.

2.4.4.1.2 *Assignment Criteria*

2.4.4.1.2.1 TennCare eligible enrollees in groups 1 through 5 will be enrolled in the CONTRACTOR's plan independent of other TennCare eligible enrollees in the same household.

2.4.4.1.2.2 To the extent possible, TennCare shall enroll all enrollees in Group 6 in the same household in the CONTRACTOR's plan.

2.4.4.1.2.3 Children eligible for TennCare as a result of being eligible for SSI will be assigned to TennCare Select (defined in Section 1 of this Agreement) but may opt-out of TennCare Select and choose another MCO.

2.4.4.1.2.4 TennCare enrollees who are children in the custody of the Department of Children's Services (DCS) will be enrolled in TennCare Select. When these enrollees exit state custody, they remain enrolled in TennCare Select for a specified period of time and then are disenrolled from TennCare Select. After disenrollment from TennCare Select, if the enrollee has a family member in an MCO (other than TennCare Select) he/she will be enrolled in that MCO. Otherwise, the enrollee will be given the opportunity to select another MCO. If the enrollee does not select another MCO, he/she will be assigned to an MCO (other than TennCare Select) using the default logic in the auto assignment process (see Section 2.4.4. 2 below).

2.4.4.1.2.5 TennCare may allow enrollment of new TennCare enrollees in TennCare Select if there is insufficient capacity in other MCOs.

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2.4.4.1.3 *Assignment Provisions for Children in State Custody*

To decrease the likelihood of recidivism, the enrollment period for children in Group 1.A who are transitioning out of state custody shall be extended by a period to be determined by TENNCARE. Children will be assigned to Group 1.B during this post-custody transition period and shall continue to receive services as specified in Section 3 including access to Best Practice Network providers, unless TENNCARE does not extend the enrollment period for children transitioning out of state custody. After the post-custody period of at least the period determined by TENNCARE, children assigned to Group 1.B shall be moved as appropriate, to Groups 2-6 and shall remain a member of the new group until the following change period, or until the child loses eligibility for TennCare. At the option of the State, children deemed to be at “prolonged” risk of state custody may remain in Group 1.B or an on-going basis.

2.4.4.2 Auto Assignment

2.4.4.2.1 TENNCARE will auto assign an enrollee to an MCO, in specified circumstances, including but not limited to, the enrollee does not request enrollment in a specified MCO, cannot be enrolled in the requested MCO, or is an adult eligible as a result of receiving SSI benefits.

2.4.4.2.2 The current auto assignment process does not apply to children eligible for TennCare as a result of being eligible for SSI or children in the state’s custody.

2.4.4.2.3 There are four different levels to the current auto assignment process:

2.4.4.2.3.1 If the enrollee was previously enrolled with an MCO and lost TennCare eligibility for a period of two (2) months or less, the enrollee will be re-enrolled with that MCO.

2.4.4.2.3.2 If the enrollee has family members in an MCO (other than TennCare Select), the enrollee will be enrolled in that MCO.

2.4.4.2.3.3 If the enrollee is a newborn, the enrollee will be assigned to his/her mother’s MCO.

2.4.4.2.3.4 If none of the above applies, the enrollee will be assigned using default logic that randomly assigns enrollees to MCOs (other than TennCare Select).

2.4.4.2.4 TENNCARE may modify the auto assignment algorithm to change or add criteria including but not limited to quality measures or cost or utilization management performance.

2.4.4.3 Immediate Eligibility for Children in State Custody

Until a final determination can be made on their TennCare eligibility, the CONTRACTOR shall accept notification from DCS that a child has entered state custody and adhere to the following requirements to insure that eligibility is provided. Upon receipt of notification from DCS, the CONTRACTOR shall determine whether or not the child is otherwise enrolled in TennCare. If the child is not currently enrolled, the CONTRACTOR shall immediately build a forty-five (45) day TennCare eligibility record effective on the date the child was placed in state custody and identify the child as a child in state custody, or group 1.A enrollee.

2.4.4.3.1 The CONTRACTOR shall generate a letter that will explain that the child has been given forty-five (45) days of coverage from their custody date, pending a final eligibility determination.

2.4.4.3.2 The CONTRACTOR is not required to assign a child for whom immediate eligibility has been established to a BPN PCP until TennCare eligibility is confirmed.

2.4.4.3.3 The CONTRACTOR shall fax the BPN enrollment form and a letter of notification to the DCS Case Manager.

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2.4.4.3.4 The CONTRACTOR's BPN staff shall work with DCS to obtain an EPSDT visit with a BPN provider within twenty-one (21) days of request but no later than thirty (30) days of enrollment.

2.4.4.3.5 After twenty-five (25) days of immediate eligibility coverage, the CONTRACTOR shall identify children whose immediate eligibility will end in twenty (20) days to the DCS Program Coordinator of Health Advocacy.

2.4.4.3.6 The child shall be eligible for the TennCare Medicaid benefit package effective on the date the child was placed in custody through the 45th day of the Immediate Eligibility period or the date of receipt of a TennCare eligibility record, whichever occurs earlier. If the CONTRACTOR receives a TennCare eligibility record prior to the end of the forty-five (45) day eligibility period, the child shall be eligible for benefits in accordance with their TennCare eligibility status effective on the date of receipt of the eligibility record.

2.4.4.4 Non-Discrimination

2.4.4.4.1 The CONTRACTOR shall accept enrollees in the order in which applications are approved and enrollees are assigned to the CONTRACTOR (whether by selection or assignment).

2.4.4.4.2 The CONTRACTOR shall accept an enrollee in the health condition the enrollee is in at the time of enrollment and shall not discriminate against individuals on the basis of health status or need for health care services.

2.4.4.5 Family Unit

If an individual is determined eligible for TennCare and has another family member already enrolled in an MCO, that individual shall be enrolled in the same MCO. This does not apply when the individual or family member is assigned to TennCare Select. If the newly enrolled family member opts to change MCOs during the 45-day change period (see Section 2.4.7.2.1), all family members in the case will be transferred to the new MCO.

2.4.5 **Effective Date of Enrollment**

2.4.5.1 Initial Enrollment of Current TennCare Enrollees

The effective date of initial enrollment in an MCO for TennCare enrollees who are enrolled in accordance with Section 2.4.4.2 shall be the date provided on the enrollment file from TENNCARE. In general, the effective date of enrollment for these enrollees will be the start date of operations.

2.4.5.2 Ongoing Enrollment

In general, a member's effective date of enrollment in the CONTRACTOR's MCO will be the member's effective date of eligibility for TennCare. For SSI enrollees the effective date of eligibility/enrollment is determined by the Social Security Administration in approving SSI coverage for the individual. The effective date of eligibility for other TennCare enrollees is the date of application or the date of the qualifying event (e.g., the date the spend down obligation is met for medically needy enrollees). The effective date on the enrollment file provided by TENNCARE to the CONTRACTOR shall govern regardless of the other provisions of this Section 2.4.5.2.

2.4.5.3 In the event the effective date of eligibility provided by TENNCARE or DCS to the CONTRACTOR for either the initial enrollment of current TennCare enrollees or ongoing enrollment precedes the start date of operations, the CONTRACTOR shall treat the enrollee as a member of the CONTRACTOR's MCO effective on the start date of operations.

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2.4.5.4 Enrollment Prior to Notification

2.4.5.4.1 Because individuals can be retroactively eligible for TennCare, and the effective date of initial enrollment in an MCO is the effective date of eligibility or start date of operations, whichever is sooner, the effective date of enrollment may occur prior to the CONTRACTOR being notified of the person's enrollment. Therefore, enrollment of individuals in the CONTRACTOR's MCO may occur without prior notice to the CONTRACTOR or enrollee.

2.4.5.4.2 The CONTRACTOR shall not be liable for the cost of any covered services prior to the effective date of enrollment/eligibility but shall be responsible for the costs of covered services obtained on or after 12:01 a.m. on the effective date of enrollment/eligibility.

2.4.5.4.3 TENNCARE shall make payments to the CONTRACTOR from the effective date of an enrollee's date of enrollment/eligibility.

2.4.5.4.4 Except for applicable TennCare cost sharing, the CONTRACTOR shall ensure that members are held harmless for the cost of covered services provided as of the effective date of enrollment with the CONTRACTOR.

2.4.6 **Eligibility and Enrollment Data**

2.4.6.1 The CONTRACTOR shall receive, process, and update enrollment files from TENNCARE, The CONTRACTOR shall also receive, process, and update enrollment files from DCS for children in state custody who are to be given immediate eligibility for a forty-five (45) day period. Enrollment data shall be updated or uploaded to the CONTRACTOR's eligibility/enrollment database(s) within twenty-four (24) hours of receipt from TENNCARE.

2.4.6.2 The CONTRACTOR agrees to accept daily eligibility updates in the form and format specified by TennCare for the purpose of identifying children in state custody and children transitioning out of state custody. Until such time as an indicator for children in state custody and children transitioning out of state custody can be added to the daily eligibility updates received from TennCare, the CONTRACTOR agrees to accept and process any adhoc report mutually agreed upon by the CONTRACTOR and TennCare to facilitate timely identification of children in state custody or children transitioning out of state custody.

2.4.6.3 The CONTRACTOR shall provide an electronic eligibility file to TENNCARE as specified and in conformance to data exchange format and method standards outlined in Section 2.23.5.

2.4.7 **Enrollment Period**

2.4.7.1 General

2.4.7.1.1 The CONTRACTOR shall be responsible for the provision and costs of all covered services provided to enrollees during their period of enrollment with the CONTRACTOR.

2.4.7.1.2 Enrollment shall begin at 12:01 a.m. on the effective date of enrollment in the CONTRACTOR's MCO and shall end at 12:00 midnight on the date that the enrollee is disenrolled from the CONTRACTOR's MCO (see Section 2.5).

2.4.7.1.3 Once enrolled in the CONTRACTOR's MCO, the member shall remain enrolled in the CONTRACTOR's MCO until or unless the enrollee is disenrolled pursuant to Section 2.5 of this Agreement.

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2.4.7.2 Changing MCOs

2.4.7.2.1 *45-Day Change Period*

After becoming eligible for TennCare and enrolling in the CONTRACTOR's MCO (whether the result of selection by the enrollee or assignment by TENNCARE), Enrollees selected for enrollment in the CONTRACTOR's plan by the State in Groups 1, 2, 3, 5 and 6 shall have one (1) opportunity, anytime during the forty-five (45) day period immediately following the date of enrollment with the CONTRACTOR's MCO or the date TENNCARE sends the member notice of enrollment in an MCO, whichever is later, to request to change MCO plans. Enrollees in Group 6 shall only be able to request to change MCO plans during this period to the extent capacity is available in another MCO serving the region.

2.4.7.2.2 *Annual Choice Period*

2.4.7.2.2.1 TENNCARE shall provide an opportunity for members to change MCOs (excluding TennCare Select) every twelve (12) months. Children eligible for TennCare as a result of being eligible for SSI may request to enroll in another MCO or re-enroll with TennCare Select.

2.4.7.2.2.2 Members who do not select another MCO will be deemed to have chosen to remain with their current MCO.

2.4.7.2.2.3 Enrollees who select a new MCO shall have one (1) opportunity anytime during the forty-five (45) day period immediately following the specified enrollment effective date in the newly selected MCO to request to change MCOs.

2.4.7.2.3 *Appeal Based on Hardship Criteria*

As provided in TennCare rules and regulations, members may appeal to TENNCARE to change MCOs based on hardship criteria.

2.4.7.2.4 *Additional Reasons for Disenrollment*

As provided in Section 2.5.2, a member may be disenrolled from the CONTRACTOR's MCO for the reasons specified therein.

2.4.8 **Transfers from Other MCOs**

2.4.8.1 The CONTRACTOR shall accept enrollees (enrolled or pending enrollment) who have been selected by the State for enrollment, from any MCO in the CONTRACTOR's service area as authorized by TENNCARE, or from any failed health plan in the CONTRACTOR's service area including any plan which is terminated in whole or in part, may become insolvent or discontinues service, or who reside in an area in which there is insufficient capacity in risk MCOs to enroll the population. The transfer of membership may occur at any time during the year. No enrollee from another MCO shall be transferred retroactively to the CONTRACTOR except as specified in Section 2.4.9. Except as provided in Section 2.4.9, the CONTRACTOR shall not be responsible for payment of any covered services incurred by enrollees transferred to the CONTRACTOR prior to the effective date of transfer to the CONTRACTOR.

2.4.8.2 Transfers from other MCOs shall be in consideration of the maximum enrollment levels established in Section 2.4.3.

2.4.8.3 To the extent possible and practical, TENNCARE shall provide advance notice to all MCOs serving a Grand Region of the impending failure of one of the MCOs serving the Grand Region; however, failure by TENNCARE to provide advance notice shall not limit in any manner the responsibility of each MCO to accept enrollees from failed MCOs.

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2.4.9 **Enrollment of Newborns**

This policy is only applicable to Group 6 enrollees.

- 2.4.9.1 TennCare-eligible newborns and their mothers, to the extent that the mother is eligible for TennCare, should be enrolled in the same MCO with the exception of newborns that are SSI eligible at birth. Newborns that are SSI eligible at birth shall be assigned to TennCare Select but may opt out and enroll in another MCO.
- 2.4.9.2 A newborn may be inadvertently enrolled in an MCO different than its mother. When such cases are identified by the CONTRACTOR, the CONTRACTOR shall immediately report to TENNCARE, in accordance with written procedures provided by TENNCARE, that a newborn has been incorrectly enrolled in an MCO different than its mother.
- 2.4.9.3 Upon receipt of notice from the CONTRACTOR or discovery by TENNCARE that a newborn has been incorrectly enrolled in an MCO different than its mother, TENNCARE shall immediately:
 - 2.4.9.3.1 Disenroll the newborn from the incorrect MCO;
 - 2.4.9.3.2 Enroll the newborn in the same MCO as its mother with the same effective date as when the newborn was enrolled in the incorrect MCO;
 - 2.4.9.3.3 Recoup any payments made to the incorrect MCO for the newborn; and
 - 2.4.9.3.4 Make payments only to the correct MCO for the period of coverage.
- 2.4.9.4 The MCO in which the newborn is correctly enrolled shall be responsible for the coverage and payment of covered services provided to the newborn for the full period of eligibility. Except as provided below, the MCO in which the newborn was incorrectly enrolled shall have no liability for the coverage or payment of any services during the period of incorrect MCO assignment. TENNCARE shall only be liable for the administrative fee payment to the correct MCO.
- 2.4.9.5 There are circumstances in which a newborn's mother may not be eligible for participation in the TennCare program. The CONTRACTOR shall be required to process claims received for services provided to newborns within the time frames specified in Section 2.22.4 of this Agreement. A CONTRACTOR shall not utilize any blanket policy which results in the automatic denial of claims for services provided to a TennCare-eligible newborn, during any period of enrollment in the CONTRACTOR's MCO, because the newborn's mother is not a member of the CONTRACTOR's MCO. However, it is recognized that in complying with the claims processing time frames specified in 2.22.4 of this Agreement, a CONTRACTOR may make payment for services provided to a TennCare-eligible newborn enrolled in the CONTRACTOR's MCO at the time of payment but the newborn's eligibility may subsequently be moved to another MCO. In such event, the MCO in which the newborn is first enrolled (first MCO) may submit supporting documentation to the MCO in which the newborn is moved (second MCO) and the second MCO shall reimburse the first MCO within thirty (30) calendar days of receipt of such properly documented request for reimbursement, for the amount expended on behalf of the newborn prior to the newborn's eligibility having been moved to the second MCO. Such reimbursement shall be the actual amount expended by the first MCO. The second MCO agrees that should the second MCO fail to reimburse the first MCO the actual amount expended on behalf of the newborn within thirty (30) calendar days of receipt of a properly documented request for payment, TENNCARE is authorized to deduct the amount owed from any funds due the second MCO and to reimburse the first MCO. In the event that the CONTRACTOR fails to reimburse the first MCO the actual amount expended on behalf of the newborn within thirty (30) calendar days of receipt of a properly documented request for payment, TENNCARE may assess liquidated damages as specified in Section 5.8.2 Should it become necessary for TENNCARE to intervene in such

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cases, both the second MCO and the first MCO agree that TENNCARE shall be held harmless by both MCOs for actions taken by TENNCARE to resolve the dispute.

2.4.10 Information Requirements Upon Enrollment

As described in Section 2.17 of this Agreement, the CONTRACTOR shall provide the following information to new members: a member handbook, a provider directory and an identification card.

2.5 DISENROLLMENT FROM AN MCO

2.5.1 General

A member may be disenrolled from the CONTRACTOR's MCO only when authorized by TENNCARE.

2.5.2 Acceptable Reasons for Disenrollment from an MCO

With the exception of enrollees in Group 4, a member may request disenrollment or be disenrolled from the CONTRACTOR's MCO if:

- 2.5.2.1 The member selects another MCO during the forty-five (45) day change period after enrollment with the CONTRACTOR's MCO and is enrolled in another MCO;
- 2.5.2.2 The member selects another MCO during the annual choice period and is enrolled in another MCO;
- 2.5.2.3 An appeal by the member to change MCOs based on hardship criteria (pursuant to TennCare rules and regulations) is decided by TENNCARE in favor of the member, and the member is enrolled in another MCO;
- 2.5.2.4 The member is assigned incorrectly to the CONTRACTOR's MCO by TENNCARE and enrolled in another MCO;
- 2.5.2.5 The member moves outside the MCO's service area and is enrolled in another MCO;
- 2.5.2.6 During the appeal process, if TENNCARE determines it is in the best interest of the enrollee and TENNCARE (see Section 2.19.2.9);
- 2.5.2.7 The member loses eligibility for TennCare;
- 2.5.2.8 TENNCARE grants members the right to terminate enrollment pursuant to Section 5.8.1, and the member is enrolled in another MCO;
- 2.5.2.9 TENNCARE may disenroll enrollees that were originally enrolled due to insufficient capacity in other TENNCARE MCOs (Group 6) at any time.
- 2.5.2.10 The CONTRACTOR no longer participates in TennCare; or
- 2.5.2.11 This Agreement expires or is terminated.

2.5.3 Unacceptable Reasons for Disenrollment from an MCO

The CONTRACTOR shall not request disenrollment of an enrollee for any reason. TENNCARE shall not disenroll members for any of the following reasons:

- 2.5.3.1 Adverse changes in the enrollee's health;
- 2.5.3.2 Pre-existing medical or behavioral health conditions;
- 2.5.3.3 High cost medical or behavioral health bills;

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- 2.5.3.4 Failure or refusal to pay applicable TennCare cost sharing responsibilities, except when this results in loss of eligibility for TennCare;
- 2.5.3.5 Enrollee's utilization of medical or behavioral health services;
- 2.5.3.6 Enrollee's diminished mental capacity; or
- 2.5.3.7 Enrollee's uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees).

2.5.4 **Informing TENNCARE of Potential Ineligibility**

Although the CONTRACTOR may not request disenrollment of a member, the CONTRACTOR shall inform TENNCARE promptly when the CONTRACTOR knows or has reason to believe that an enrollee may satisfy any of the conditions for termination from the TennCare program as described in TennCare rules and regulations.

2.5.5 **Effective Date of Disenrollment**

2.5.5.1 Member Requested Disenrollment

All TENNCARE approved disenrollment requests from enrollees shall be effective on or before the first calendar day of the second month following the month of an enrollee's request to disenroll from an MCO. The effective date shall be indicated on the termination record sent by TENNCARE.

2.5.5.2 Other Disenrollments

The effective date of disenrollments other than at the request of the member shall be determined by TENNCARE and indicated on the termination record.

5. **Renumbered Section 2.6.1 and 2.6.2 shall be deleted and replaced in its entirety and shall read as follows:**

2.6.1 **CONTRACTOR Covered Benefits**

- 2.6.1.1 The CONTRACTOR shall cover the physical health and behavioral health services/benefits outlined below. Additional requirements for behavioral health services are included in Section 2.6.5 and Attachment I.
- 2.6.1.2 The CONTRACTOR shall integrate the delivery of physical health and behavioral health services. This shall include but not be limited to the following:
 - 2.6.1.2.1 The CONTRACTOR shall operate a member services toll-free phone line (see Section 2.18.1) that is used by all members, regardless of whether they are calling about physical health and/or behavioral health services. The CONTRACTOR shall not have a separate number for members to call regarding behavioral health services. The CONTRACTOR may either route the call to another entity or conduct a "warm transfer" to another entity, but the CONTRACTOR shall not require an enrollee to call a separate number regarding behavioral health services.
 - 2.6.1.2.2 If the CONTRACTOR's nurse triage/nurse advice line is separate from its member services line, the CONTRACTOR shall comply with the requirements in Section 2.6.1 as applied to the nurse triage/nurse advice line. The number for the nurse triage/nurse advice line shall be the same for all members, regardless of whether they are calling about physical health and/or behavioral health services, and the CONTRACTOR may either route calls to another entity or

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conduct “warm transfers,” but the CONTRACTOR shall not require an enrollee to call a separate number.

2.6.1.2.3 As required in Section 2.9.5, the CONTRACTOR shall ensure continuity and coordination between physical health and behavioral health services and ensure collaboration between physical health and behavioral health providers.

2.6.1.2.4 Each of the CONTRACTOR’s disease management programs (see Section 2.8) shall address the needs of members who have co-morbid physical health and behavioral health conditions.

2.6.1.2.5 As required in Section 2.9.4.2.2, the CONTRACTOR shall provide MCO case management to members with co-morbid physical health and behavioral health conditions. These members should have a single case manager that is trained to provide MCO case management to enrollees with co-morbid physical health and behavioral health conditions. If a member with co-morbid physical and behavioral health conditions does not have a single case manager, the CONTRACTOR shall ensure, at a minimum, that the member's MCO case managers collaborate and communicate in an effective and ongoing manner.

2.6.1.2.6 If the CONTRACTOR uses different Systems for physical health services and behavioral health services, these systems shall be interoperable. In addition, the CONTRACTOR shall have the capability to integrate data from the different systems.

2.6.1.2.7 The CONTRACTOR’s administrator/project director (see Section 2.29.1.3.1) shall be the primary contact for TENNCARE regarding all issues, regardless of the type of service, and shall not direct TENNCARE to other entities.

2.6.1.3 CONTRACTOR Physical Health Benefits Chart

SERVICE	BENEFIT LIMIT
Inpatient Hospital Services	<p>Medicaid/Standard Eligible, Age 21 and older: As medically necessary. Inpatient rehabilitation hospital facility services are not covered for adults unless determined by the CONTRACTOR to be a cost effective alternative (see Section 2.6.7).</p> <p>Medicaid/Standard Eligible, Under age 21: As medically necessary, including rehabilitation hospital facility.</p>
Outpatient Hospital Services	As medically necessary.
Physician Inpatient Services	As medically necessary.
Physician Outpatient Services/Community Health Clinic Services/Other Clinic Services	As medically necessary.

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SERVICE	BENEFIT LIMIT
<p>TENnderCare Services</p>	<p>Medicaid/Standard Eligibles, Age 21 and older: Not covered.</p> <p>Medicaid/Standard Eligibles, Under age 21: Covered as medically necessary, except that the screenings do not have to be medically necessary. Children may also receive screenings in-between regular checkups if a parent or caregiver believes there is a problem.</p> <p>Screening, interperiodic screening, diagnostic and follow-up treatment services as medically necessary in accordance with federal and state requirements. See Section 2.7.5.</p>
<p>Preventive Care Services</p>	<p>As described in Section 2.7.4.</p>
<p>Lab and X-ray Services</p>	<p>As medically necessary.</p>
<p>Hospice Care</p>	<p>As medically necessary. Shall be provided by a Medicare-certified hospice.</p>
<p>Dental Services</p>	<p>Dental Services shall be provided by the Dental Benefits Manager.</p> <p>However, the facility, medical and anesthesia services related to the dental service that are not provided by a dentist or in a dentist's office shall be covered services provided by the CONTRACTOR when the dental service is covered by the DBM. This requirement only applies to Medicaid/Standard Eligibles Under age 21.</p>
<p>Vision Services</p>	<p>Medicaid/Standard Eligible, Age 21 and older: Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of refractive state), shall be covered as medically necessary. Routine periodic assessment, evaluation, or screening of normal eyes and examinations for the purpose of prescribing fitting or changing eyeglass and/or contact lenses are not covered. One pair of cataract glasses or lenses is covered for adults following cataract surgery.</p> <p>Medicaid/Standard Eligible, Under age 21: Preventive, diagnostic, and treatments services (including eyeglasses) are covered as medically necessary in accordance with TENnderCare requirements.</p>
<p>Home Health Care</p>	<p>As medically necessary in accordance with <u>Newberry</u>.</p>
<p>Pharmacy Services</p>	<p>Pharmacy services shall be provided by the Pharmacy Benefits Manager (PBM), unless otherwise described below.</p> <p>The CONTRACTOR shall be responsible for reimbursement of injectable drugs obtained in an office/clinic setting and to providers providing both home infusion services and the drugs and biologics. The CONTRACTOR shall require that all home infusion claims contain National Drug Code (NDC) coding and unit information to be paid.</p> <p>Services reimbursed by the CONTRACTOR shall not be included in any pharmacy benefit limits established by TENNCARE for pharmacy services (see Section 2.6.2.2).</p>

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SERVICE	BENEFIT LIMIT
Durable Medical Equipment (DME)	<p>As medically necessary.</p> <p>Specified DME services shall be covered/non-covered in accordance with TennCare rules and regulations.</p>
Medical Supplies	<p>As medically necessary.</p> <p>Specified medical supplies shall be covered/non-covered in accordance with TennCare rules and regulations.</p>
Emergency Air And Ground Ambulance Transportation	<p>As medically necessary.</p>
Non-emergency Medical Transportation (including Non-Emergency Ambulance Transportation)	<p>Covered non-emergency medical transportation (NEMT) services are necessary non-emergency transportation services provided to convey members to and from TennCare covered services (see definition in Exhibit A to Attachment XIV). Non emergency transportation services shall be provided in accordance with federal law and the Bureau of TennCare’s rules and policies and procedures. TennCare covered services (see definition in Exhibit A to Attachment XIV) include services provided to a member by a non-contract or non-TennCare provider if (a) the service is covered by Tennessee’s Medicaid State Plan or Section 1115 demonstration waiver, (b) the provider could be a TennCare provider for that service, and (c) the service is covered by a third party resource (see definition in Section 1 of the Agreement).</p> <p>If a member requires assistance, an escort (as defined in TennCare rules and regulations) may accompany the member; however, only one (1) escort is allowed per member (see TennCare rules and regulations). Except for fixed route and commercial carrier transport, the CONTRACTOR shall not make separate or additional payment to a NEMT provider for an escort.</p> <p>Covered NEMT services include having an accompanying adult ride with a member if the member is under age eighteen (18). Except for fixed route and commercial carrier transport, the CONTRACTOR shall not make separate or additional payment to a NEMT provider for an adult accompanying a member under age eighteen (18).</p> <p>The CONTRACTOR is not responsible for providing NEMT to any service that is being provided to the member through a HCBS waiver.</p> <p>Mileage reimbursement, car rental fees, or other reimbursement for use of a private automobile (as defined in Exhibit A to Attachment XIV) is not a covered NEMT service.</p> <p>If the member is a child, transportation shall be provided in accordance with TENNderCare requirements (see Section 2.7.5.4.6).</p> <p>Failure to comply with the provisions of this Section may result in liquidated damages.</p>

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SERVICE	BENEFIT LIMIT
Renal Dialysis Services	As medically necessary.
Private Duty Nursing	As medically necessary and when prescribed by an attending physician for treatment and services rendered by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), who is not an immediate relative.
Speech Therapy	<p>Medicaid/Standard Eligible, Age 21 and older: Covered as medically necessary by a Licensed Speech Therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic or personality disorder.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with TENNderCare requirements.</p>
Occupational Therapy	<p>Medicaid/Standard Eligible, Age 21 and older: Covered as medically necessary when provided by a Licensed Occupational Therapist to restore, improve, or stabilize impaired functions.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with TENNderCare requirements.</p>
Physical Therapy	<p>Medicaid/Standard Eligible, Age 21 and older: Covered as medically necessary when provided by a Licensed Physical Therapist to restore, improve, or stabilize impaired functions.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with TENNderCare requirements.</p>
Organ and Tissue Transplant And Donor Organ Procurement	<p>Medicaid/Standard Eligible, Age 21 and older: All medically necessary and non-investigational/experimental organ and tissue transplants, as covered by Medicare, are covered. These include, but may not be limited to: Bone marrow/Stem cell; Cornea; Heart; Heart/Lung; Kidney; Kidney/Pancreas; Liver; Lung; Pancreas; and Small bowel/Multi-visceral.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with TENNderCare requirements. Experimental or investigational transplants are not covered.</p>

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SERVICE	BENEFIT LIMIT
Reconstructive Breast Surgery	Covered in accordance with TCA 56-7-2507, which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy, as well as surgical procedures on the non-diseased breast to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast to establish symmetry with the diseased breast shall only be covered if the surgical procedure performed on a non-diseased breast occurs within five (5) years of the date the reconstructive breast surgery was performed on a diseased breast.
Chiropractic Services	<p>Medicaid/Standard Eligible, Age 21 and older: Not covered unless determined by the CONTRACTOR to be a cost effective alternative (see Section 2.6.7).</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with TENNderCare requirements.</p>

2.6.1.4 CONTRACTOR Behavioral Health Benefits Chart

SERVICE	BENEFIT LIMIT
Psychiatric Inpatient Hospital Services (including physician services)	As medically necessary.
24-hour Psychiatric Residential Treatment	<p>Medicaid/Standard Eligible, Age 21 and older: As medically necessary.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary.</p>
Outpatient Mental Health Services (including physician services)	As medically necessary.
Inpatient, Residential & Outpatient Substance Abuse Benefits¹	<p>Medicaid/Standard Eligible, Age 21 and older: Limited to ten (10) days detox, \$30,000 in medically necessary lifetime benefits, unless otherwise described in the 2008 Mental Health Parity Act as determined by TennCare.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary.</p>
Mental Health Case Management	As medically necessary.
Psychiatric-Rehabilitation Services	As medically necessary.
Behavioral Health Crisis Services	As necessary.
Lab and X-ray Services	As medically necessary.

SERVICE	BENEFIT LIMIT
Non-emergency Medical Transportation (including Non-Emergency Ambulance Transportation)	Same as for physical health (see Section 2.6.1.3 above).

¹When medically appropriate, services in a licensed substance abuse residential treatment facility may be substituted for inpatient substance abuse services. Methadone clinic services are not covered for adults.

2.6.2 TennCare Benefits Provided by TENNCARE

TennCare shall be responsible for the payment of the following benefits:

2.6.2.1 Dental Services

Except as provided in Section 2.6.1.3 of this Agreement, dental services shall not be provided by the CONTRACTOR but shall be provided by a dental benefits manager (DBM) under contract with TENNCARE. Coverage of dental services is described in TennCare rules and regulations.

2.6.2.2 Pharmacy Services

Except as provided in Section 2.6.1.3 of this Agreement, pharmacy services shall not be provided by the CONTRACTOR but shall be provided by a pharmacy benefits manager (PBM) under contract with TENNCARE. Coverage of pharmacy services is described in TennCare rules and regulations. TENNCARE does not cover pharmacy services for enrollees who are dually eligible for TennCare and Medicare.

2.6.2.3 Institutional Services and Alternatives to Institutional Services

For qualified enrollees in accordance with TennCare policies and/or TennCare rules and regulations, TENNCARE covers the costs of long-term care institutional services in a nursing facility or an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or alternatives to institutional services provided through the Home and Community Based Services (HCBS) waivers.

6. Existing Sections 2-3.5 “Dental Services”, 2-3.8 “Institutional Services and Alternatives to Institutional Services”, 2-3.9 “Coordination with Medicare”, 2-3.14 “Use of a Drug Formulary”, 2-3.19 “Coordination of MCO and PBM Benefits”, and 2-3.20 “Coordination with Department of Education” shall be deleted in their entirety and the remaining Sections shall be renumbered accordingly, including references thereto. The newly renumbered Section 2.6.5 shall be deleted and replaced in its entirety as follows.

2.6.5 Behavioral Health Services

2.6.5.1 General Provisions

2.6.5.1.1 The CONTRACTOR shall provide all behavioral health services as described in this Section, Section 2.6.5 and Attachment V.

2.6.5.1.2 The CONTRACTOR shall provide behavioral health services in accordance with best practice guidelines, rules and regulations, and policies and procedures issued by TDMHDD and approved by the Bureau of TennCare, including but not limited to “Managed Care Standards for Delivery of Behavioral Health Services”.

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- 2.6.5.1.3 The CONTRACTOR shall ensure that all members receiving behavioral health services from providers whose primary focus is to render behavioral health services have individualized treatment plans. Providers included in this requirement are:
 - 2.6.5.1.3.1 Community mental health agencies;
 - 2.6.5.1.3.2 Case management agencies;
 - 2.6.5.1.3.3 Psychiatric rehabilitation agencies;
 - 2.6.5.1.3.4 Psychiatric and substance abuse residential treatment facilities; and
 - 2.6.5.1.3.5 Psychiatric and substance abuse inpatient facilities.
- 2.6.5.1.4 Individualized treatment plans shall be completed within thirty (30) calendar days of the start date of service and updated every six (6) months, or more frequently as clinically appropriate. The treatment plans shall be developed, negotiated and agreed upon by the members and/or their support systems in face-to-face encounters and shall be used to identify the treatment needs necessary to meet the members' stated goals. The duration and intensity of treatment shall promote the recovery and resilience of members and shall be documented in the treatment plans.
- 2.6.5.2 Psychiatric Inpatient Hospital Services
 - 2.6.5.2.1 The CONTRACTOR shall ensure that all psychiatric inpatient hospitals serving children, youth, and adults separate members by age and render developmental age appropriate services.
 - 2.6.5.2.2 The CONTRACTOR shall require that all psychiatric inpatient facilities are accredited by the Joint Commission and accept voluntary and involuntary admissions.
- 2.6.5.3 24-Hour Psychiatric Residential Treatment
 - 2.6.5.3.1 The CONTRACTOR shall ensure that 24-hour psychiatric residential treatment facilities (RTFs) serving children, youth, and adults separate members by age and render developmental age appropriate services.
 - 2.6.5.3.2 The CONTRACTOR shall ensure RTFs have the capacity to render short term crisis stabilization and long-term treatment and rehabilitation.
 - 2.6.5.3.3 The CONTRACTOR shall ensure all RTFs meet local housing codes.
 - 2.6.5.3.4 The CONTRACTOR shall ensure all RTFs are accredited by a State-recognized accreditation organization as required by 42 CFR 441.151.
- 2.6.5.4 Outpatient Mental Health Services
 - 2.6.5.4.1 The CONTRACTOR shall ensure that outpatient mental health providers (including providers of intensive outpatient and providers of partial hospitalization services) serving children, youth and adults separate members by age and render developmental age appropriate services.
 - 2.6.5.4.2 The CONTRACTOR shall ensure outpatient mental health providers are capable of rendering services both on and off site, as appropriate, depending on the services being rendered. On site services include, but are not limited to intensive outpatient services, partial hospitalization and many types of therapy. Off site services include but are not limited to intensive in home service for children and youth and home and community treatment for adults.

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2.6.5.5 Inpatient, Residential & Outpatient Substance Abuse Services

2.6.5.5.1 The CONTRACTOR shall provide substance abuse treatment through inpatient, residential and outpatient services.

2.6.5.5.2 Detoxification services may be rendered as part of inpatient, residential or outpatient services, as clinically appropriate. The CONTRACTOR shall ensure all member detoxifications are supervised by Tennessee licensed physicians with a minimum daily re-evaluations by a physician or a registered nurse.

2.6.5.6 Mental Health Case Management

2.6.5.6.1 The CONTRACTOR shall provide mental health case management services only through providers licensed by the State to provide mental health outpatient services.

2.6.5.6.2 The CONTRACTOR shall provide mental health case management services according to mental health case management standards set by the State and outlined in Attachment I. Mental health case management services shall consist of two (2) levels of service as specified in Attachment I.

2.6.5.6.3 The CONTRACTOR shall require its providers to collect and submit individual encounter records for each mental health case management visit, regardless of the method of payment by the CONTRACTOR. The CONTRACTOR shall identify and separately report “level 1” and “level 2” mental health case management encounters outlined in Attachment I.

2.6.5.6.4 The CONTRACTOR shall require mental health case managers to involve the member, the member’s family or parent(s), or legally appointed representative, PCP and other agency representatives, if appropriate and authorized by the member as required, in mental health case management activities.

2.6.5.6.5 The CONTRACTOR shall ensure the continuing provision of mental health case management services to members under the conditions and time frames indicated below:

2.6.5.6.5.1 Members receiving mental health case management services at the start date of operations shall be maintained in mental health case management until such time as the member no longer qualifies on the basis of medical necessity or refuses treatment;

2.6.5.6.5.2 Members discharged from psychiatric inpatient hospitals and psychiatric residential treatment facilities shall be evaluated for mental health case management services and provided with appropriate behavioral health follow-up services; and

2.6.5.6.5.3 The CONTRACTOR shall review the cases of members referred by PCPs or otherwise identified to the CONTRACTOR as potentially in need of mental health case management services and shall contact and offer such services to all members who meet medical necessity criteria.

2.6.5.7 Psychiatric Rehabilitation Services

The CONTRACTOR shall provide psychiatric rehabilitation services in accordance with the requirements in Attachment I. As described in Attachment I, the covered array of services available under psychiatric rehabilitation are psychosocial rehabilitation, supported employment, peer support, illness management and recovery, and supported housing. An individual may receive one or more of these services and may receive different services from different providers.

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2.6.5.8 Behavioral Health Crisis Services

2.6.5.8.1 *Entry into the Behavioral Health Crisis Services System*

2.6.5.8.1.1 The State shall maintain a statewide toll-free telephone number for entry into the behavioral health crisis system. This line shall be for any individual in the general population for the purposes of providing immediate phone intervention by trained crisis specialists and dispatch of mobile crisis teams.

2.6.5.8.1.2 The CONTRACTOR shall ensure that the crisis telephone line is linked to an appropriate crisis service team staffed by qualified crisis service providers in order to provide crisis intervention services to members.

2.6.5.8.1.3 As required in Section 2.11.5.3, the CONTRACTOR shall contract with specified crisis service teams for both adults and children as directed by the State.

2.6.5.8.1.4 The CONTRACTOR shall require the crisis service teams to provide telephone and walk-in triage screening services, telephone and face-to-face crisis intervention/assessment services, and follow-up telephone or face-to-face assessments to ensure the safety of the member until the member's treatment begins and/or the crisis is alleviated and/or stabilized.

2.6.5.8.1.5 Prior to admission to a psychiatric inpatient hospital on an involuntary basis, the CONTRACTOR shall ensure that the member has been evaluated by a crisis team. In addition, the CONTRACTOR shall ensure that Tennessee's statutory requirement for a face-to-face evaluation by a mandatory pre-screening agent (MPA), is conducted to assess eligibility for emergency involuntary admission to an RMHI (Regional Mental Health Institute) and determine whether all available less drastic alternatives services and supports are unsuitable.

2.6.5.8.2 *Behavioral Health Crisis Respite and Crisis Stabilization Services*

2.6.5.8.2.1 The CONTRACTOR shall ensure access to behavioral health crisis respite and crisis stabilization services.

2.6.5.8.2.2 Behavioral health crisis respite services provide immediate shelter to members with emotional/behavioral problems who are in need of emergency respite. The CONTRACTOR shall ensure that behavioral health crisis respite services are provided in a CONTRACTOR approved community location.

2.6.5.8.2.3 The CONTRACTOR shall ensure behavioral health crisis stabilization services are rendered at sites licensed by the State. These services are more intensive than regular behavioral health crisis services in that they require more secure environments, highly trained staff, and typically have longer stays.

2.6.5.8.3 The CONTRACTOR shall monitor behavioral health crisis services and report information to TENNCARE on a quarterly basis as described in Section 2.30.4.4.

2.6.5.9 Clinically Related Group (CRG) and Target Population Group (TPG) Assessments

2.6.5.9.1 The CONTRACTOR shall provide CRG/TPG assessments in response to requests from members or legally appointed representatives or, in the case of minors, the members' parents or legally appointed representatives, behavioral health providers, PCPs, or the State.

2.6.5.9.2 The CONTRACTOR shall complete CRG/TPG assessments within fourteen (14) calendar days of the requests. The CONTRACTOR shall not require prior authorization in order for a member to receive a CRG/TPG assessment.

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- 2.6.5.9.3 The CONTRACTOR shall ensure that its contract providers are trained and that there is sufficient capacity to perform CRG/TPG assessments. The CONTRACTOR shall require providers to use the CRG/TPG assessment form(s) as appropriate, prescribed by and in accordance with the policies of the state. The CRG/TPG assessments shall be subject to review and prior written approval by the State.
- 2.6.5.9.4 The CONTRACTOR shall identify persons in need of CRG/TPG assessments. The CONTRACTOR shall use the CRG/TPG assessments to identify persons who are SPMI or SED for reporting and tracking purposes, in accordance with the definitions contained in Section 1.
- 2.6.5.9.5 The CONTRACTOR shall ensure that providers who perform CRG/TPG assessments have been trained and authorized by the State to perform CRG/TPG assessments. Certified trainers shall be responsible for providing rater training within their agencies.
- 2.6.5.9.6 The CONTRACTOR shall reject all CRG/TPG assessments completed by unapproved raters. The CONTRACTOR shall report on rejected assessments as required in Section 2.30.4.6.
- 2.6.5.9.7 The CONTRACTOR shall conduct audits of CRG/TPG assessments for accuracy and conformity to state policies and procedures. The CONTRACTOR shall audit all providers conducting these assessments on at least an annual basis. The methodology for these audits and the results of these audits shall be reported as required in Sections 2.30.4.7 and 2.30.4.8.
- 2.6.5.10 Judicial Services
- 2.6.5.10.1 The CONTRACTOR shall provide covered court ordered behavioral health services to its members pursuant to court order(s). The CONTRACTOR shall furnish these services in the same manner as services furnished to other members.
- 2.6.5.10.2 The CONTRACTOR shall provide for behavioral health services to its members in accordance with state law. Specific laws employed include the following:
 - 2.6.5.10.2.1 Psychiatric treatment for persons found by the court to require judicial psychiatric hospitalization (TCA 33-6 part 4 and part 5). The CONTRACTOR may apply medical necessity criteria to the situation after seventy-two (72) hours of emergency services, unless there is a court order prohibiting release.
 - 2.6.5.10.2.2 Judicial review of discharge for persons hospitalized by a circuit, criminal or juvenile court (TCA 33-6-708);
 - 2.6.5.10.2.3 Access to and provision of mandatory outpatient psychiatric treatment and services to persons who are discharged from psychiatric hospitals after being hospitalized (TCA 33-6, Part 6);
 - 2.6.5.10.2.4 Inpatient psychiatric examination for up to forty-eight (48) hours for persons whom the court has ordered to be detained for examination but who have been unwilling to be evaluated for hospital admission (TCA 33-3-607);
 - 2.6.5.10.2.5 Voluntary psychiatric hospitalization for persons when determined to be medically necessary, subject to the availability of suitable accommodations (TCA 33-6, Part 2); and
 - 2.6.5.10.2.6 Voluntary psychiatric hospitalization for persons with a severe impairment when determined to be medically necessary but who do not meet the criteria for emergency involuntary hospitalization, subject to the availability of suitable accommodations (TCA 33-6, Part 3).

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2.6.5.11 Mandatory Outpatient Treatment

2.6.5.11.1 The CONTRACTOR shall provide mandatory outpatient treatment for individuals found not guilty by reason of insanity following a thirty (30) to sixty (60) calendar day inpatient evaluation. Treatment can be terminated only by the court pursuant to TCA 33-7-303(b).

2.6.5.11.2 The State will assume responsibility for all forensic services other than the mandatory outpatient treatment service identified in Section 2.6.5.11.1 (TCA 33-7-301(a), 33-7-301(b), 33-7-303(a) and 33-7-303(c)).

7. The newly renumbered Section 2.6.8 shall be deleted and replaced in its entirety.

2.6.8 Advance Directives

2.6.8.1 The CONTRACTOR shall maintain written policies and procedures for advance directives that comply with all federal and state requirements concerning advance directives, including but not limited to 42 CFR 422.128, 438.6 and 489 Subpart I; TCA 32-11-101 *et seq.*, 34-6-201 *et seq.*, and 68-11-201 through 68-11-224; and any requirements as stipulated by the member. Any written information provided by the CONTRACTOR shall reflect changes in state law by the effective date specified in the law, if not specified then within thirty (30) calendar days after the effective date of the change.

2.6.8.2 The CONTRACTOR shall provide its policies and procedures to all members eighteen (18) years of age and older and shall educate members about their ability to direct their care using this mechanism and shall specifically designate which staff members and/or contract providers are responsible for providing this education.

2.6.8.3 The CONTRACTOR shall educate its staff about its policies and procedures on advance directives, situations in which advance directives may be of benefit to members, and their responsibility to educate members about this tool and assist them to make use of it.

2.6.8.4 The CONTRACTOR, for behavioral health services, shall provide its policies and procedures to all members sixteen (16) years of age and older and shall educate members about their ability to direct their care using advance directives including the use of Declarations for Mental Health Treatment under TCA Title 33, Chapter 6, Part 10. The CONTRACTOR shall specifically designate staff members and/or providers responsible for providing this education.

8. The newly renumbered Section 2.6.13 shall be deleted and replaced in its entirety and references thereto shall be updated accordingly.

2.6.13 TENNderCare

2.6.13.1 General Provisions

2.6.13.1.1 The CONTRACTOR shall provide TENNderCare services to members under age twenty-one (21) in accordance with TennCare and federal requirements including TennCare rules and regulations, TennCare policies and procedures, 42 USC 1396a(a)(43), 1396d(a) and (r), 42 CFR Part 441, Subpart B, the Omnibus Budget Reconciliation Act of 1989, and the State Medicaid Manual. TENNderCare services means early and periodic screening, diagnosis and treatment of members under age twenty-one (21) to ascertain children's individual (or individualized/or on an individual basis) physical and mental defects, and providing treatment to correct or ameliorate, or prevent from worsening defects and physical and mental illnesses and conditions discovered by the screening services, regardless of whether the required service is a covered benefit as described in Section 2.6.1.

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- 2.6.13.1.2 The CONTRACTOR shall use the name “TENnderCare” in describing or naming the State’s EPSDT program or services. This requirement is applicable for all policies, procedures and other material, regardless of the format or media. No other names or labels shall be used.
- 2.6.13.1.3 The CONTRACTOR shall have written policies and procedures for the TENnderCare program that include coordinating services with child-serving agencies and providers, providing all medically necessary TENnderCare services to all eligible members under the age of twenty-one (21) regardless of whether the service is included in the Medicaid State Plan, and conducting outreach and education. The CONTRACTOR shall ensure the availability and accessibility of required health care resources and shall help members and their parents or legally appointed representatives use these resources effectively.
- 2.6.13.1.4 The CONTRACTOR shall be responsible for and comply with all provisions related to screening, vision, dental, and hearing services (including making arrangements for necessary follow-up if all components of a screen cannot be completed in a single visit).
- 2.6.13.1.5 The CONTRACTOR shall:
 - 2.6.13.1.5.1 Require that providers provide TENnderCare services;
 - 2.6.13.1.5.2 Require that providers make appropriate referrals and document said referrals in the member’s medical record;
 - 2.6.13.1.5.3 Educate contract providers about proper coding and encourage them to submit the appropriate diagnosis codes identified by TENNCARE in conjunction with evaluation and management procedure codes for TENnderCare services;
 - 2.6.13.1.5.4 Educate contract providers about how to submit claims with appropriate codes and modifiers as described in standardized billing requirements (e.g., CPT, HCPCS, etc.) and require that they adjust billing methodology according to described components of said procedure codes/modifiers; and
 - 2.6.13.1.5.5 Monitor provider compliance with required TENnderCare activities including compliance with proper coding.
- 2.6.13.1.6 The CONTRACTOR shall require that its contract providers notify the CONTRACTOR in the event a screening reveals the need for other health care services and the provider is unable to make an appropriate referral for those services. Upon notification of the inability to make an appropriate referral, the CONTRACTOR shall secure an appropriate referral and contact the member to offer scheduling assistance and transportation for members lacking access to transportation. In the event the failed referral is for dental services, the CONTRACTOR shall coordinate with the DBM to arrange for services.
- 2.6.13.1.7 The CONTRACTOR shall not require prior authorization for periodic and interperiodic screens conducted by PCPs. The CONTRACTOR shall provide all medically necessary covered services regardless of whether the need for such services was identified by a provider who had received prior authorization from the CONTRACTOR or from a contract provider.
- 2.6.13.1.8 The CONTRACTOR shall have a tracking system to monitor each TENnderCare eligible member’s receipt of the required screening, diagnosis, and treatment services. The tracking system shall have the ability to generate immediate reports on each member’s TENnderCare status, reflecting all encounters reported more than sixty (60) days prior to the date of the report.
- 2.6.13.1.9 In the event that a member under sixteen (16) years of age is seeking behavioral health TENnderCare services and the member’s parent(s), or legally appointed representative is unable to accompany the member to the examination, the CONTRACTOR shall require that its providers either contact the member’s parent(s), or legally appointed representative to discuss the findings and inform the family of any other necessary health care, diagnostic

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services, treatment or other measures recommended for the member or notify the MCO to contact the parent(s), or legally appointed representative with the results.

2.6.13.2 Member Education and Outreach

2.6.13.2.1 The CONTRACTOR shall be responsible for outreach activities and for informing members who are under the age of twenty-one (21), or their parent or legally appointed representative, of the availability of TENNderCare services. All TENNderCare member materials shall be submitted to TENNCARE for written approval prior to distribution in accordance with Section 2.17.1 and shall be made available in accordance with the requirements specified in Section 2.17.2.

2.6.13.2.2 The CONTRACTOR shall have a minimum of six (6) “outreach contacts” per member per calendar year in which it provides information about TENNderCare to members. The minimum “outreach contacts” include: one (1) member handbook as described in Section 2.17.4, four (4) quarterly member newsletters as described in Section 2.17.5, and one (1) reminder notice issued before a screening is due. The reminder notice shall include an offer of transportation and scheduling assistance.

2.6.13.2.2.1 The CONTRACTOR shall conduct New Member Calls for all new members under the age of twenty-one (21) to inform them of TENNderCare services including assistance with appointment scheduling and transportation to appointments.

2.6.13.2.2.2 The CONTRACTOR shall have the ability to conduct EPSDT outreach in formats appropriate to members who are blind, deaf, illiterate or have Limited English Proficiency. At least one of the 6 outreach attempts identified above shall advise members regarding how to request and/or access such assistance and/or information. The CONTRACTOR shall collaborate with agencies that have established procedures for working with special populations in order to develop effective outreach materials.

2.6.13.2.3 The CONTRACTOR shall have a mechanism for systematically notifying families when TENNderCare screens are due.

2.6.13.2.4 As part of its TENNderCare policies and procedures, the CONTRACTOR shall have a written process for following up with members who do not get their screenings timely. This process for follow up shall include provisions for documenting all outreach attempts and maintaining records of efforts made to reach out to members who have missed screening appointments or who have failed to receive regular check-ups. The CONTRACTOR shall make at least one (1) effort per quarter in excess of the six (6) “outreach contacts” to get the member in for a screening. The efforts, whether written or oral, shall be different each quarter. The CONTRACTOR is prohibited from simply sending the same letter four (4) times.

2.6.13.2.5 The CONTRACTOR shall have a process for determining if a member who is eligible for TENNderCare has used no services within a year and shall make two (2) reasonable attempts to re-notify such members about TENNderCare. The attempts must be different in format or message. One (1) of these attempts can be a referral to DOH for a screen.. (These two (2) attempts are in addition to the one (1) attempt per quarter mentioned in Section 2.6.13.2.4 above.)

2.6.13.2.6 The CONTRACTOR shall require that providers have a process for documenting services declined by a parent or legally appointed representative or mature competent child, specifying the particular service was declined. This process shall meet all requirements outlined in Section 5320.2.A of the State Medicaid Manual.

2.6.13.2.7 The CONTRACTOR shall make and document a minimum of two (2) reasonable attempts to find a member within thirty (30) days of receipt of mail returned as undeliverable. At least one (1) of these attempts shall be by phone.

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- 2.6.13.2.8 The CONTRACTOR shall make available to members and families accurate lists of names and phone numbers of contract providers who are currently accepting TennCare members as described in Section 2.17.7 of this Agreement.
- 2.6.13.2.9 The CONTRACTOR shall target specific informing activities to pregnant women and families with newborns. Provided that the CONTRACTOR is aware of the pregnancy, the CONTRACTOR shall inform all pregnant women prior to the estimated delivery date about the availability of TENNderCare services for their children. The CONTRACTOR shall offer TENNderCare services for the child when it is born.
- 2.6.13.2.10 The CONTRACTOR shall provide member education and outreach in community settings. Outreach events shall be conducted in each Grand Region covered by this Agreement, in accordance with the following specifications:
 - 2.6.13.2.10.1 Outreach events shall number a minimum of 5 per region per quarter.
 - 2.6.13.2.10.2 At least 3 of the minimum quarterly outreach activities must be conducted in urban or suburban areas, and 2 must be conducted in rural areas. Results of the CONTRACTOR's 416 report and HEDIS report, as well as county demographics, must be utilized in determining counties for targeted activities and in developing strategies for TennCare enrollees who are in or at risk of DCS custody or have special healthcare needs.
 - 2.6.13.2.10.3 The CONTRACTOR shall contact a minimum of 15 state agencies or community-based organizations per quarter, to either educate them on services available through the MCO or to develop outreach and educational initiatives. All of the agencies engaged must be those who serve TennCare enrollees who are in or at risk of DCS custody or have special healthcare needs.
- 2.6.13.3 Screening
 - 2.6.13.3.1 The CONTRACTOR shall provide periodic comprehensive child health assessments meaning, "regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth."
 - 2.6.13.3.2 At a minimum, these screens shall include periodic and interperiodic screens and be provided at intervals which meet reasonable standards of medical, behavioral and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care. The State has determined that "reasonable standards of medical and dental practice" are those standards set forth in the American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care for medical practice and American Academy of Pediatric Dentistry (AAPD) guidelines for dental practice. Tools used for screening shall be consistent with the screening guidelines recommended by the State which are available on the TennCare web site. These include, but are not limited to recommended screening guidelines for developmental/behavioral surveillance and screening, hearing screenings, and vision screenings.
 - 2.6.13.3.3 The screens shall include, but not be limited to:
 - 2.6.13.3.3.1 Comprehensive health and developmental history (including assessment of physical and mental health development and dietary practices);
 - 2.6.13.3.3.2 Comprehensive unclothed physical examination, including measurements (the child's growth shall be compared against that considered normal for the child's age and gender);
 - 2.6.13.3.3.3 Appropriate immunizations scheduled according to the most current Advisory Committee on Immunization Practices (ACIP) schedule according to age and health history;

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- 2.6.13.3.3.4 Appropriate vision and hearing testing provided at intervals which meet reasonable standards of medical practice and at other intervals as medically necessary to determine the existence of suspected illness or condition;
- 2.6.13.3.3.5 Appropriate laboratory tests (including lead toxicity screening appropriate for age and risk factors). All children are considered at risk and shall be screened for lead poisoning. All children shall receive a screening blood lead test at twelve (12) and twenty-four (24) months of age. Children between the ages of thirty-six (36) months and seventy-two (72) months of age shall receive a screening blood lead test if they have not been previously screened for lead poisoning. A blood lead test shall be used when screening Medicaid-eligible children. A blood lead test equal to or greater than ten (10) ug/dL obtained by capillary specimen (finger stick) shall be confirmed by using a venous blood sample; and
- 2.6.13.3.3.6 Health education which includes anticipatory guidance based on the findings of all screening. Health education should include counseling to both members and members' parents or to the legally appointed representative to assist in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.
- 2.6.13.3.4 The CONTRACTOR shall encourage providers to refer children to dentists for periodic dental screens beginning no later than three (3) years of age and earlier as needed (as early as six (6) to twelve (12) months in accordance with the American Academy of Pediatric Dentistry (AAPD) guidelines) and as otherwise appropriate.
- 2.6.13.3.5 The CONTRACTOR shall establish a procedure for PCPs or other providers completing TENNderCare screenings to refer TENNderCare eligible members requiring behavioral health services to appropriate providers.
- 2.6.13.4 Services
- 2.6.13.4.1 Should screenings indicate a need, the CONTRACTOR shall provide all necessary health care, diagnostic services, treatment, and other measures described in 42 USC 1396d(a) (Section 1905(a) of the Social Security Act) to correct or ameliorate or prevent from worsening defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid State plan (see Section 2.6.13.4.8). This includes, but is not limited to, the services detailed below.
- 2.6.13.4.2 The CONTRACTOR shall provide treatment for defects in vision and hearing, including eyeglasses and hearing aids.
- 2.6.13.4.3 The CONTRACTOR shall coordinate with the DBM to ensure that TENNderCare eligible members receive dental care services furnished by direct referral to a dentist, at as early an age as necessary, and at intervals which meet reasonable standards of dental practice as determined by the State and at other intervals as medically necessary to determine the existence of a suspected illness or condition.
- 2.6.13.4.4 The CONTRACTOR shall not require prior authorization or written PCP referral in order for a member to obtain a mental health or substance abuse assessment, whether the assessment is requested as follow-up to a TENNderCare screening or an interperiodic screening. This requirement shall not preclude the CONTRACTOR from requiring notification for a referral for an assessment. Furthermore, the CONTRACTOR shall establish a procedure for PCPs, or other providers, completing TENNderCare screenings, to refer members under the age of twenty-one (21) for a mental health or substance abuse assessment.
- 2.6.13.4.5 For services not covered by Section 1905(a) of the Social Security Act, but found to be needed as a result of conditions disclosed during screening and diagnosis, the CONTRACTOR shall provide referral assistance as required by 42 CFR 441.61, including referral to providers and State health agencies.

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2.6.13.4.6 Transportation Services

2.6.13.4.6.1 The CONTRACTOR shall provide transportation assistance for a child and for the child's escort or accompanying adult, including related travel expenses, cost of meals, and lodging en route to and from TennCare covered services. The requirement to provide the cost of meals shall not be interpreted to mean that a member (or the child's escort or accompanying adult) can request meals while in transport to and from care. Reimbursement for meals and lodging shall only be provided when transportation for a TennCare covered service cannot be completed in one (1) day and would require an overnight stay.

2.6.13.4.6.2 The CONTRACTOR shall offer transportation and scheduling assistance to all members under age twenty-one (21) who do not have access to transportation in order to access covered services. This may be accomplished through various means of communication to members, including but not limited to, member handbooks, TENNderCare outreach notifications, etc.

2.6.13.4.7 Services for Elevated Blood Lead Levels

2.6.13.4.7.1 The CONTRACTOR shall provide follow up for elevated blood lead levels in accordance with the State Medicaid Manual, Part 5. The Manual currently says that children with blood lead levels equal to or greater than ten (10) ug/dL should be followed according to CDC guidelines. These guidelines include follow up blood tests and investigations to determine the source of lead, when indicated.

2.6.13.4.7.2 The CONTRACTOR shall provide for any follow up service within the scope of the federal Medicaid statute, including diagnostic or treatment services determined to be medically necessary when elevated blood lead levels are identified in children. Such services would include both MCO case management services and a one (1) time investigation to determine the source of lead.

2.6.13.4.7.3 The CONTRACTOR is responsible for the primary environmental lead investigation—commonly called a “lead inspection”—for children when elevated blood levels suggest a need for such an investigation.

2.6.13.4.7.4 If the lead inspection does not reveal the presence of lead paint in the home, there may be a need for other testing, such as risk assessments involving water and soil sampling or inspections of sites other than the primary residence if the child spends a substantial amount of time in another location. The CONTRACTOR is not responsible for either the risk assessments or the lead inspection at the secondary site. However, the CONTRACTOR shall contact the DOH when these services are indicated as this agency is responsible for these services.

2.6.13.4.7.5 CONTRACTOR reimbursement for the primary environmental investigations is limited to the items specified in Part 5 of the State Medicaid Manual. These items include the health professional's time and activities during the on-site investigation of the child's primary residence. They do not include testing of environmental substances such as water, paint, or soil.

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2.6.13.4.8 Services Chart

Pursuant to federal and state requirements, TennCare enrollees under the age of 21 are eligible for all services listed in Section 1905(a) of the Social Security Act. These services, and the entity responsible for providing them to TennCare enrollees under the age of 21, are listed below. Notwithstanding any other provision of this Agreement, the CONTRACTOR shall provide all services for which “MCO” is identified as the responsible entity to members under the age of 21. All services, other than TENNderCare screens and interperiodic screens, must be medically necessary in order to be covered by the CONTRACTOR. The CONTRACTOR shall provide all medically necessary TENNderCare covered services regardless of whether or not the need for such services was identified by a provider whose services had received prior authorization from the CONTRACTOR or by a contract provider.

Services Listed in Social Security Act Section 1905(a)		Responsible Entity in Tennessee	Comments
(1) Inpatient hospital services (other than services in an institution for mental diseases)		MCO	
(2)(A) Outpatient hospital services		MCO	
(2)(B) Rural health clinic services (RHCs)		MCO	MCOs are not required to contract with RHCs if the services are available through other contract providers.
(2)(C) Federally-qualified health center services (FQHCs)		MCO	MCOs are not required to contract with FQHCs if they can demonstrate adequate provider capacity without them.
(3) Other laboratory and X-ray services		MCO	
(4)(A) Nursing facility services for individuals age 21 and older			Not applicable for TENNderCare
(4)(B) EPSDT services		MCO for physical health and behavioral health services; DBM for dental services except as described in Section 2.6.1.3; PBM for pharmacy services as described except as in Section 2.6.1.3	
(4)(C) Family planning services and supplies		MCO; PBM for pharmacy services except as described in Section 2.6.1.3	
(5)(A) Physicians’ services furnished by a physician, whether furnished in the office, the patient’s home, a hospital, or a nursing facility		MCO	
(5)(B) Medical and surgical services furnished by a dentist		DBM except as described in Section 2.6.1.3	

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Services Listed in Social Security Act Section 1905(a)		Responsible Entity in Tennessee	Comments
(6) Medical care, or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law		MCO	See Item (13)
(7) Home health care services		MCO	
(8) Private duty nursing services		MCO	
(9) Clinic services		MCO	
(10) Dental services		DBM except as described in Section 2.6.1.3	
(11) Physical therapy and related services		MCO	
(12) Prescribed drugs, dentures, and prosthetic devices, and eyeglasses		MCO; PBM for pharmacy services except as described in Section 2.6.1.3; DBM for dentures	
(13) Other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level		MCO for physical health and behavioral health services; DBM for dental services except as described in Section 2.6.1.3; PBM for pharmacy services except as described in Section 2.6.1.3	The following are considered practitioners of the healing arts in Tennessee law: ¹ <ul style="list-style-type: none"> • Alcohol and drug abuse counselor • Athletic trainer • Audiologist • Certified acupuncturist • Certified master social worker • Certified nurse practitioner • Certified professional counselor • Certified psychological assistant • Chiropractic physician • Chiropractic therapy assistant • Clinical pastoral therapist • Dentist • Dental assistant • Dental hygienist • Dietitian/nutritionist • Dispensing optician • Electrologist • Emergency medical personnel

¹ This list was provided by the Tennessee Department of Health.

Services Listed in Social Security Act Section 1905(a)		Responsible Entity in Tennessee	Comments
			<ul style="list-style-type: none"> • First responder • Hearing instrument specialist • Laboratory personnel • Licensed clinical perfusionist • Licensed clinical social worker • Licensed practical nurse • Licensed professional counselor • Marital and family therapist, certified • Marital and family therapist, licensed • Massage therapist • Medical doctor • Medical doctor (special training) • Midwives and nurse midwives • Nurse aide • Occupational therapist • Occupational therapy assistant • Optometrist • Osteopathic physician • Pharmacist • Physical therapist • Physical therapist assistant • Physician assistant • Podiatrist • Psychological examiner • Psychologist • Registered nurse • Registered certified reflexologist • Respiratory care assistant • Respiratory care technician • Respiratory care therapist • Senior psychological examiner • Speech pathologist • Speech pathology aide • X-ray op in chiropractic

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Services Listed in Social Security Act Section 1905(a)		Responsible Entity in Tennessee	Comments
			physician's office <ul style="list-style-type: none"> • X-ray op in MD office • X-ray op in osteopathic office • X-ray op in podiatrist's office
(14) Inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases			Not applicable for TENNderCare
(15) Services in an intermediate care facility for the mentally retarded		TENNCARE	
(16) Inpatient psychiatric services for individuals under age 21		MCO	
(17) Services furnished by a nurse-midwife		MCO	The MCOs are not required to contract with nurse-midwives if the services are available through other contract providers.
(18) Hospice care		MCO	
(19) Case management services		MCO	
(20) Respiratory care services		MCO	
(21) Services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner		MCO	The MCOs are not required to contract with PNPs or CFNPs if the services are available through other contract providers.
(22) Home and community care for functionally disabled elderly individuals			Not applicable for TENNderCare
(23) Community supported living arrangements services			Not applicable for TENNderCare
(24) Personal care services		MCO	
(25) Primary care case management services			Not applicable
(26) Services furnished under a PACE program			Not applicable for TENNderCare
(27) Any other medical care, and any other type of remedial care recognized under state law.		MCO for physical and behavioral health services; DBM for dental services except as described in Section 2.6.1.3; PBM for pharmacy services except as described in Section 2.6.1.3	See Item (13)

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- 2.6.13.4.8.1 Note 1: “Targeted case management services,” which are listed under Section 1915(g)(1), are not TENNderCare services except to the extent that the definition in Section 1915(g)(2) is used with Item (19) above.
- 2.6.13.4.8.2 Note 2: “Psychiatric residential treatment facility” is not listed in Social Security Act Section 1905(a). It is, however, defined in 42 CFR 483.352 as “a facility other than a hospital, that provides psychiatric services, as described in subpart D of part 441 of this chapter, to individuals under age twenty-one (21), in an inpatient setting.”
- 2.6.13.4.8.3 Note 3: “Rehabilitative” services are differentiated from “habilitative” services in federal law. “Rehabilitative” services, which are TENNderCare services, are defined in 42 CFR 440.130(d) as services designed “for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level.” “Habilitative” services, which are not TENNderCare services, are defined in Section 1915(c)(5) as services designed “to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings.”
- 2.6.13.4.8.4 Note 4: Certain services are covered under a Home and Community Based waiver but are not TENNderCare services because they are not listed in the Social Security Act Section 1905(a). These services include habilitation, prevocational, supported employment services, homemaker services and respite services. (See Section 1915(c)(4).)
- 2.6.13.4.8.5 Note 5: Certain services are not coverable even under a Home and Community Based waiver and are not TENNderCare services. These services include room and board, and special education and related services which are otherwise available through a Local Education Agency. (See Section 1915(c)(5).)

2.6.13.5 Children with Special Health Care Needs

Children with special health care needs are those children who are in the custody of DCS. As provided in Section 2.4.4, TennCare enrollees who are in the custody of DCS will be enrolled in TennCare Select.

9. Section 2.6 shall be amended by adding a new Section 2.6.15 which shall read as follows:

2.6.15 **Cost Sharing for Services**

2.6.15.1 General

The CONTRACTOR and all providers and subcontractors shall not require any cost sharing responsibilities for covered services except to the extent that cost sharing responsibilities are required for those services by TENNCARE in accordance with TennCare rules and regulations, including but not limited to, holding enrollees liable for debt due to insolvency of the CONTRACTOR or non-payment by the State to the CONTRACTOR. Further, the CONTRACTOR and all providers and subcontractors shall not charge enrollees for missed appointments.

2.6.15.2 Preventive Services

TennCare cost sharing responsibilities shall apply to covered services other than the preventive services described in TennCare rules and regulations.

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2.6.15.3 Cost Sharing Schedule

The current TennCare cost sharing schedule is included in this Agreement as Attachment XII. The CONTRACTOR shall not waive or use any alternative cost sharing schedules, unless required by TENNCARE.

2.6.15.4 Provider Requirements

2.6.15.4.1 Providers or collection agencies acting on the provider's behalf may not bill enrollees for amounts other than applicable TennCare cost sharing responsibilities for covered services, including but not limited to, services that the State or the CONTRACTOR has not paid for, except as permitted by TennCare rules and regulations and as described below. Providers may seek payment from an enrollee only in the following situations.

2.6.15.4.1.1 If the services are not covered services and, prior to providing the services, the provider informed the enrollee that the services were not covered. The provider shall inform the enrollee of the non-covered service and have the enrollee acknowledge the information. If the enrollee still requests the service, the provider shall obtain such acknowledgment in writing prior to rendering the service. Regardless of any understanding worked out between the provider and the enrollee about private payment, once the provider bills an MCO for the service that has been provided, the prior arrangement with the enrollee becomes null and void without regard to any prior arrangement worked out with the enrollee.

2.6.15.4.1.2 If the enrollee's TennCare eligibility is pending at the time services are provided and if the provider informs the person they will not accept TennCare assignment whether or not eligibility is established retroactively. Regardless of any understanding worked out between the provider and the enrollee about private payment, once the provider bills an MCO for the service the prior arrangement with the enrollee becomes null and void without regard to any prior arrangement worked out with the enrollee.

2.6.15.4.1.3 If the enrollee's TennCare eligibility is pending at the time services are provided, however, all monies collected, except applicable TennCare cost sharing amounts shall be refunded when a claim is submitted to an MCO because the provider agreed to accept TennCare assignment once retroactive TennCare eligibility was established. (The monies collected shall be refunded as soon as a claim is submitted and shall not be held conditionally upon payment of the claim).

2.6.15.4.1.4 If the services are not covered because they are in excess of an enrollee's hard benefit limit, and the provider complies with applicable TennCare rules and regulations.

2.6.15.4.2 The CONTRACTOR shall require, as a condition of payment, that the provider accept the amount paid by the CONTRACTOR or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payer) plus any applicable amount of TennCare cost sharing responsibilities due from the enrollee as payment in full for the service. Except in the circumstances described above, if the CONTRACTOR is aware that a provider, or a collection agency acting on the provider's behalf, bills an enrollee for amounts other than the applicable amount of TennCare cost sharing responsibilities due from the enrollee, the CONTRACTOR shall notify the provider and demand that the provider and/or collection agency cease such action against the enrollee immediately. If a provider continues to bill an enrollee after notification by the CONTRACTOR, the CONTRACTOR shall refer the provider to the Tennessee Bureau of Investigation.

10. The existing Sections 2-4 "Service Delivery Requirements", 2-5 "Services Not Covered", 2-6 "Marketing and Enrollee Materials", 2-7 "Medical Management", 2-8 "Complaints and Appeals", 2-9 "Administration and Management", 2-10 "Reporting Requirements", 2-11 "Accounting Requirements", 2-12 "Availability of Records", 2-13 "Audit Requirements", 2-

14 “Independent Review of the CONTRACTOR, 2-15 “Accessibility of Monitoring”, 2-16 “Changes Resulting from Monitoring and Audit”, 2-17 “Use of Subcontracts”, 2-18 “Provider Agreements”, 2-19 “Fidelity Bonds – Net Worth”, 2-20 “Insurance”, 2-21 “Ownership and Financial Disclosure”, 2-22 Community Service Area, 2-23 “CONTRACTOR Appeal Rights, 2-24 “Non-Discrimination Compliance”, 2-25 “Processing and Payment of Supplemental Payments”, 26 “Processing and Payment of Critical Access Hospital Payments”, 2-27 “Processing and Payment of Essential Hospital Payments”, 2-28 “Notice of Legal Action”, and Section 2-29 “Prohibition of Illegal Immigrants” shall be deleted in their entirety and replaced by new Sections 2.7 through 2.30 as described below and all references thereto shall be amended accordingly.

2.7 LEFT BLANK INTENTIONALLY

2.8 DISEASE MANAGEMENT

2.8.1 General

2.8.1.1 The CONTRACTOR shall establish and operate a disease management (DM) program for each of the following conditions:

2.8.1.1.1 Maternity care management, in particular high-risk obstetrics;

2.8.1.1.2 Diabetes;

2.8.1.1.3 Congestive heart failure;

2.8.1.1.4 Asthma;

2.8.1.1.5 Coronary artery disease;

2.8.1.1.6 Chronic-obstructive pulmonary disease;

2.8.1.1.7 Bipolar disorder;

2.8.1.1.8 Major depression; and

2.8.1.1.9 Schizophrenia.

2.8.1.2 Each DM program shall utilize evidence-based clinical practice guidelines (hereafter referred to as the guidelines) that have been formally adopted by the CONTRACTOR’s Quality Management/Quality Improvement (QM/QI) committee or other clinical committee and patient empowerment strategies to support the provider-patient relationship and the plan of care. For the conditions listed in 2.8.1.1 through 2.8.1.6, the guidelines shall include a requirement to conduct a mental health and substance abuse screening. The DM programs for bipolar disorder, major depression, and schizophrenia shall include the use of the evidence-based practice for co-occurring disorders.

2.8.1.3 The DM programs shall emphasize the prevention of exacerbation and complications of the conditions as evidenced by decreases in emergency room utilization and inpatient hospitalization and/or improvements in condition-specific health status indicators.

2.8.1.4 The CONTRACTOR shall develop and maintain DM program policies and procedures, which shall include program descriptions. These policies and procedures shall include, for each of the conditions listed above, the following:

2.8.1.4.1 The definition of the target population;

2.8.1.4.2 Member identification strategies;

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- 2.8.1.4.3 The guidelines;
 - 2.8.1.4.4 Written description of the stratification levels for each of the conditions, including member criteria and associated interventions;
 - 2.8.1.4.5 Program content;
 - 2.8.1.4.6 Methods for informing and educating members;
 - 2.8.1.4.7 Methods for informing and educating providers; and
 - 2.8.1.4.8 Program evaluation.
- 2.8.1.5 As part of its DM program policies and procedures, the CONTRACTOR shall also address how the DM programs will coordinate with MCO case management activities, in particular for members who would benefit from both.

2.8.2 **Member Identification Strategies**

- 2.8.2.1 The CONTRACTOR shall have a systematic method of identifying and enrolling eligible members in each DM program.
- 2.8.2.2 The CONTRACTOR shall operate its disease management programs using an “opt out” methodology, meaning that disease management services shall be provided to eligible members unless they specifically ask to be excluded.

2.8.3 **Stratification**

As part of the DM programs, the CONTRACTOR shall classify eligible members into stratification levels according to condition severity or other clinical or member provided information. The DM programs shall tailor the program content and education activities, for each stratification level.

2.8.4 **Program Content**

Each DM program shall include the development of treatment plans, as described in NCQA Disease Management program content, that serve as the outline for all of the activities and interventions in the program. At a minimum the activities and interventions associated with the treatment plan shall address condition monitoring, patient adherence to the treatment plan, consideration of other co-morbidities, and condition-related lifestyle issues.

2.8.5 **Informing and Educating Members**

The DM programs shall educate members and/or their caregivers regarding their particular condition(s) and needs. This information shall be provided upon enrollment in the DM program. The DM programs shall educate members to increase their understanding of their condition(s), the factors that impact their health status (e.g., diet and nutrition, lifestyle, exercise, medication compliance), and to empower members to be more effective in self-care and management of their health so they:

- 2.8.5.1 Are proactive and effective partners in their care;
- 2.8.5.2 Understand the appropriate use of resources needed for their care;
- 2.8.5.3 Identify precipitating factors and appropriate responses before they require more acute intervention; and
- 2.8.5.4 Are compliant and cooperative with the recommended treatment plan.

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2.8.6 **Informing and Educating Providers**

As part of the DM programs, the CONTRACTOR shall educate providers regarding the guidelines and shall distribute the guidelines to providers who are likely to treat enrollees with the DM conditions. This includes, but is not limited to, PCPs and specialists involved in treating that particular condition. The CONTRACTOR shall also provide each PCP with a list of their patients enrolled in each DM program upon the member's initial enrollment and at least annually thereafter. The CONTRACTOR shall provide specific information to the provider concerning how the program(s) works. The DM's provider education shall be designed to increase the providers' adherence to the guidelines in order to improve the members' conditions.

2.8.7 **Program Evaluation (Satisfaction and Effectiveness)**

2.8.7.1 The CONTRACTOR shall evaluate member satisfaction with the DM services (as described by NCQA) by systematically analyzing feedback from members and analyzing member complaints and inquiries at least annually. The feedback on satisfaction shall be specific to DM programs.

2.8.7.1.1 A written summary, of member satisfaction with the DM program, shall be included in the annual DM report.

2.8.7.2 The CONTRACTOR shall establish measurable benchmarks and goals for each DM program and shall evaluate the programs using these benchmarks and goals. These benchmarks and goals shall be specific to each condition but should include:

2.8.7.2.1 Performance measured against at least two important clinical aspects of the guidelines associated with each DM program;

2.8.7.2.2 The rate of emergency department utilization and inpatient hospitalization;

2.8.7.2.3 Neonatal Intensive Care Unit (NICU) days for births associated with members enrolled in the maternity care management program;

2.8.7.2.4 Appropriate HEDIS measures;

2.8.7.2.5 The passive participation rates (as defined by NCQA) and the number of individuals participating in each level of each of the DM programs;

2.8.7.2.6 Cost savings;

2.8.7.2.7 Member adherence to treatment plans; and

2.8.7.2.8 Provider adherence to the guidelines.

2.8.7.3 The CONTRACTOR shall report on DM activities as required in Section 2.30.5.

2.8.8 **Obesity Disease Management**

In addition to the aforementioned DM program requirements, the CONTRACTOR shall have a DM program for obesity that is provided as a cost effective alternative service (see Section 2.6.7). The CONTRACTOR may fulfill this requirement by entering into a provider agreement with Weight Watchers and then referring/authorizing eligible obese and overweight members to participate in a Weight Watchers program. If the CONTRACTOR identifies another weight management program as the cost effective alternative service, the CONTRACTOR shall include a narrative of the program (including target population and description of services) as part of its quarterly disease management report (see Section 2.30.5.1) applicable to the quarter in which the program was implemented.

2.9 SERVICE COORDINATION

2.9.1 General

- 2.9.1.1 The CONTRACTOR shall be responsible for the management, coordination, and continuity of care for all its TennCare members and shall develop and maintain policies and procedures to address this responsibility.
- 2.9.1.2 The CONTRACTOR shall:
 - 2.9.1.2.1 Coordinate care for children in DCS custody;
 - 2.9.1.2.2 Coordinate care between PCPs and specialists;
 - 2.9.1.2.3 Perform reasonable preventive health case management services, have mechanisms to assess the quality and appropriateness of services furnished, and provide appropriate referral and scheduling assistance;
 - 2.9.1.2.4 Document authorized referrals in its utilization management system;
 - 2.9.1.2.5 Monitor members with ongoing medical or behavioral health conditions;
 - 2.9.1.2.6 Identify members using emergency department services inappropriately to assist in scheduling follow-up care with PCPs and/or appropriate specialists to improve continuity of care and establish a medical home;
 - 2.9.1.2.7 Maintain and operate a formalized hospital and/or institutional discharge planning program;
 - 2.9.1.2.8 Coordinate hospital and/or institutional discharge planning that includes post-discharge care, as appropriate;
 - 2.9.1.2.9 Maintain an internal tracking system that identifies the current preventive services screening status and pending preventive services screening due dates for each member; and
 - 2.9.1.2.10 Authorize services provided by non-contract providers, as required in this Agreement (see, e.g., Section 2.13).

2.9.2 Transition of New Members

- 2.9.2.1 In the event an enrollee entering the CONTRACTOR's MCO is receiving medically necessary covered services in addition to or other than prenatal services (see below for enrollees receiving only prenatal services) the day before enrollment, the CONTRACTOR shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided by contract or non-contract providers. The CONTRACTOR shall provide continuation of such services for up to ninety (90) calendar days or until the member may be reasonably transferred without disruption, whichever is less. The CONTRACTOR may require prior authorization for continuation of the services beyond thirty (30) calendar days however the CONTRACTOR is prohibited from denying authorization solely on the basis that the provider is a non-contract provider.
- 2.9.2.2 In the event an enrollee entering the CONTRACTOR's MCO is in her first trimester of pregnancy and is receiving medically necessary covered prenatal care services the day before enrollment, the CONTRACTOR shall be responsible for the costs of continuation of such medically necessary prenatal care services, including prenatal care, delivery, and post-natal care, without any form of prior approval and without regard to whether such services are being provided by a contract or non-contract provider until such time as the CONTRACTOR can reasonably transfer the member to a contract provider without impeding service delivery that might be harmful to the member's health.

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- 2.9.2.3 In the event an enrollee entering the CONTRACTOR's MCO is in her second or third trimester of pregnancy and is receiving medically necessary covered prenatal care services the day before enrollment, the CONTRACTOR shall be responsible for providing continued access to the prenatal care provider (whether contract or non-contract provider) through the postpartum period.
- 2.9.2.4 The CONTRACTOR shall ensure that the member is held harmless by the provider for the costs of medically necessary covered services except for applicable TennCare cost sharing amounts described in Section 2.6.15 and in Attachment XII of this Agreement.
- 2.9.2.5 The CONTRACTOR shall develop and maintain policies and procedures regarding the transition of new members.

2.9.3 Transition of Care

- 2.9.3.1 The CONTRACTOR shall actively assist members with chronic or acute medical or behavioral health conditions in transitioning to another provider when their current provider has terminated participation with the CONTRACTOR. The CONTRACTOR shall provide continuation of such services for up to ninety (90) calendar days or until the member may be reasonably transferred without disruption of care, whichever is less. The CONTRACTOR shall allow continued access to the provider through the postpartum period for members in their second or third trimester of pregnancy.
- 2.9.3.2 The CONTRACTOR shall actively assist members in transitioning to another provider when there are changes in providers. The CONTRACTOR shall have transition policies that, at a minimum, include the following:
 - 2.9.3.2.1 A schedule which ensures transfer does not create a lapse in service;
 - 2.9.3.2.2 A mechanism for timely information exchange (including transfer of the member record);
 - 2.9.3.2.3 A mechanism for assuring confidentiality;
 - 2.9.3.2.4 A mechanism for allowing a member to request and be granted a change of provider;
 - 2.9.3.2.5 An appropriate schedule for transitioning members from one (1) provider to another when there is medical necessity for ongoing care.
 - 2.9.3.2.6 Specific transition language on the following special populations:
 - 2.9.3.2.6.1 Children who are SED;
 - 2.9.3.2.6.2 Adults who are SPMI;
 - 2.9.3.2.6.3 Persons who have addictive disorders;
 - 2.9.3.2.6.4 Persons who have co-occurring disorders of both mental health and substance abuse disorders; and
 - 2.9.3.2.6.5 Persons with behavioral health conditions who also have a developmental disorder (dually diagnosed). These members shall be allowed to remain with their providers of the services listed below for the minimum time frames set out below as long as the services continue to be medically necessary. The CONTRACTOR may shorten these transition time frames only when the provider of services is no longer available to serve the member or when a change in providers is agreed to in writing by the member.
 - 2.9.3.2.6.5.1 Mental health case management: three (3) months;

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- 2.9.3.2.6.5.2 Psychiatrist: three (3) months;
- 2.9.3.2.6.5.3 Outpatient behavioral health therapy: three (3) months;
- 2.9.3.2.6.5.4 Psychosocial rehabilitation and supported employment: three (3) months; and
- 2.9.3.2.6.5.5 Psychiatric inpatient or residential treatment and supportive housing: six (6) months.

2.9.4 MCO Case Management

- 2.9.4.1 The CONTRACTOR shall maintain an MCO case management program that includes the following components:
 - 2.9.4.1.1 A systematic approach to identify eligible members;
 - 2.9.4.1.2 Assessment of member needs;
 - 2.9.4.1.3 Development of an individualized plan of care;
 - 2.9.4.1.4 Implementation of the plan of care, including coordination of care that actively links the member to providers and support services; and
 - 2.9.4.1.5 Program Evaluation (Satisfaction and Effectiveness).
- 2.9.4.2 The CONTRACTOR shall provide MCO case management to members who are at high risk or have unique, chronic, or complex needs. This shall include but not be limited to:
 - 2.9.4.2.1 Members with co-occurring mental illness and substance abuse and/or co-morbid physical health and behavioral health conditions.
- 2.9.4.3 The CONTRACTOR has the option of allowing members to be enrolled in both MCO case management and a disease management program.
- 2.9.4.4 Eligible members shall be offered MCO case management services. However, member participation shall be voluntary.
- 2.9.4.5 The CONTRACTOR shall develop a process to inform members and providers about the availability of MCO case management and to inform the member's PCP and/or appropriate specialist when a member has been assigned to the MCO case management program.
- 2.9.4.6 The CONTRACTOR shall use utilization data, including pharmacy data provided by TENNCARE or its PBM (see Section 2.9.7), to identify members for MCO case management services as appropriate. In particular, the CONTRACTOR shall track utilization data to determine when a member exceeded the ED threshold (see Section 2.14.1.10.2).

2.9.5 Coordination and Collaboration Between Physical Health and Behavioral Health

2.9.5.1 General

As provided in Section 2.6.1 of this Agreement, the CONTRACTOR shall be responsible for providing a full continuum of physical health and behavioral health services. The CONTRACTOR shall ensure communication and coordination between PCPs and medical specialists. The CONTRACTOR shall also be responsible for ensuring continuity and coordination between covered physical and behavioral health services and ensuring collaboration between physical health and behavioral health providers. The CONTRACTOR shall develop policies and procedures that address key elements in meeting this requirement. These elements include, but are not limited to, screening for behavioral health needs (including the screening tool), referral to physical and behavioral health providers, exchange of information, confidentiality, assessment, treatment plan development, collaboration, MCO

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case management and disease management, provider training, and monitoring implementation and outcomes.

2.9.5.2 Subcontracting for Behavioral Health Services

If the CONTRACTOR subcontracts for the provision of behavioral health services, the CONTRACTOR shall develop and implement a written agreement with the subcontractor regarding the coordination of services provided by the CONTRACTOR and those provided by the subcontractor. The agreement shall address the responsibilities of the CONTRACTOR and the subcontractor regarding, at a minimum, the items identified in Section 2.9.5.1 as well as prior authorization, claims payment, claims resolution, contract disputes, and reporting. The subcontract shall comply with all of the requirements regarding subcontracts included in Section 2.26 of this Agreement.

2.9.5.3 Screening for Behavioral Health Needs

2.9.5.3.1 The CONTRACTOR shall ensure that the need for behavioral health services is systematically identified by and addressed by the member's PCP at the earliest possible time following initial enrollment of the member in the CONTRACTOR's MCO or after the onset of a condition requiring mental health and/or substance abuse treatment.

2.9.5.3.2 The CONTRACTOR shall encourage PCPs and other providers to use a screening tool prior approved in writing by the State as well as other mechanisms to facilitate early identification of behavioral health needs.

2.9.5.4 Referrals to Behavioral Health Providers

The CONTRACTOR shall ensure through screening that members with a need for behavioral health services, particularly members with SED/SPMI are appropriately referred to behavioral health providers. The CONTRACTOR shall develop provider education and training materials to ensure that physical health providers know when and how to refer members who need specialty behavioral health services. This shall include education about behavioral health services, including the recovery process and resilience for children. The CONTRACTOR shall develop a referral process to be used by its providers, including what information must be exchanged and when to share this information.

2.9.5.5 Referrals to PCPs

The CONTRACTOR shall ensure that members with both physical health and behavioral health needs are appropriately referred to their PCPs for treatment of their physical health needs. The CONTRACTOR shall develop provider education and training materials to ensure that behavioral health providers know when and how to refer members who need physical health services. The CONTRACTOR shall develop a referral process to be used by its providers. The referral process shall include providing a copy of the physical health consultation and results to the behavioral health provider.

2.9.5.6 Behavioral Health Assessment and Treatment Plan

The CONTRACTOR's policies and procedures shall identify the role of physical health and behavioral health providers in assessing a member's behavioral health needs and developing an individualized treatment plan. For members with chronic physical conditions that require ongoing treatment who also have behavioral health needs, the CONTRACTOR shall encourage participation of both the member's physical health provider (PCP or specialist) and behavioral health provider in the assessment and individualized treatment plan development process as well as the ongoing provision of services.

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2.9.5.7 MCO Case Management and Disease Management

The CONTRACTOR shall use its MCO case management and disease management programs (see Sections 2.9.4 and 2.9) to support the continuity and coordination of covered physical and behavioral health services and the collaboration between physical health and behavioral health providers. The CONTRACTOR has the option to allow members, e.g., members who have been determined to be high risk based on disease management stratification (see Section 2.8.3), to be enrolled in both a disease management program and MCO case management.

2.9.5.8 Monitoring

The CONTRACTOR shall evaluate and monitor the effectiveness of its policies and procedures regarding the continuity and coordination of covered physical and behavioral health services and collaboration between physical and behavioral health providers. This shall include, but not be limited to, an assessment of the appropriateness of the diagnosis, treatment, and referral of behavioral health disorders commonly seen by PCPs; an evaluation of the appropriateness of psychopharmacological medication; and analysis of data regarding access to appropriate services. Based on these monitoring activities, the CONTRACTOR shall develop and implement interventions to improve continuity, coordination, and collaboration for physical and behavioral health services.

2.9.6 **Coordination and Collaboration Among Behavioral Health Providers**

2.9.6.1 The CONTRACTOR shall ensure communication and coordination between mental health providers and substance abuse providers, including:

2.9.6.1.1 Assignment of a responsible party to ensure communication and coordination occur;

2.9.6.1.2 Determination of the method of mental health screening to be completed by substance abuse service providers; screening and assessment tools to be designated by TENNCARE;

2.9.6.1.3 Determination of the method of substance abuse screening to be completed by mental health service providers; screening and assessment tools to be designated by TENNCARE;

2.9.6.1.4 Description of how treatment plans will be coordinated between behavioral health service providers; and

2.9.6.1.5 Assessment of cross training of behavioral health providers: mental health providers being trained on substance abuse issues and substance abuse providers being trained on mental health issues.

2.9.6.2 The CONTRACTOR shall ensure coordination between the children and adolescent service delivery system as they transition into the adult mental health service delivery system, through such activities as communicating treatment plans and exchange of information.

2.9.6.3 The CONTRACTOR shall coordinate inpatient and community services, including the following requirements related to hospital admission and discharge:

2.9.6.3.1 The outpatient provider shall be involved in the admissions process when possible; if the outpatient provider is not involved, the outpatient provider shall be notified promptly of the member's hospital admission;

2.9.6.3.2 Psychiatric hospital and residential treatment facility discharges shall not occur without a discharge plan in which the member has participated (an outpatient visit shall be scheduled before discharge, which ensures access to proper provider/medication follow-up; also, an appropriate placement or housing site shall be secured prior to discharge);

2.9.6.3.3 An evaluation shall be performed prior to discharge to determine if mental health case management services are medically necessary. Once deemed medically necessary, the mental

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health case manager shall be involved in discharge planning; if there is no mental health case manager, then the outpatient provider shall be involved; and

- 2.9.6.3.4 A procedure to ensure continuity of care regarding medication shall be developed and implemented.
- 2.9.6.4 The CONTRACTOR shall identify and develop community alternatives to inpatient hospitalization for those members who are receiving inpatient psychiatric facility services who could leave the facility if appropriate community or residential care alternatives were available in the community. In the event the CONTRACTOR does not provide appropriate community alternatives, the CONTRACTOR shall remain financially responsible for the continued inpatient care of these individuals.
- 2.9.6.5 The CONTRACTOR is responsible for providing a discharge plan as outlined in Section 2.9.6.3.2.

2.9.7 Coordination of Pharmacy Services

- 2.9.7.1 Except as provided in Section 2.6.1.3, the CONTRACTOR is not responsible for the provision and payment of pharmacy benefits; TENNCARE contracts with a pharmacy benefits manager (PBM) to provide these services. However, the CONTRACTOR shall coordinate with the PBM as necessary to ensure that members receive appropriate pharmacy services without interruption. The CONTRACTOR shall monitor and manage its contract providers as it relates to prescribing patterns and its members as it relates to utilization of prescription drugs. The CONTRACTOR shall participate in regularly scheduled meetings with the PBM and TENNCARE to discuss operational and programmatic issues.
- 2.9.7.2 The CONTRACTOR shall accept and maintain prescription drug data from TENNCARE or its PBM.
- 2.9.7.3 The CONTRACTOR shall monitor and manage members by, at a minimum, conducting the activities as described below:
 - 2.9.7.3.1 Analyzing prescription drug data and/or reports provided by the PBM to identify high-utilizers and other members who inappropriately use pharmacy services and assign them to the MCO case management and/or disease management programs as appropriate;
 - 2.9.7.3.2 Analyzing prescription drug data and/or reports provided by the PBM to identify potential pharmacy lock-in candidates and referring them to TENNCARE; and
 - 2.9.7.3.3 Regularly providing information to members about appropriate prescription drug usage. At a minimum, this information shall be included in the Member Handbook and in at least two (2) quarterly member newsletters within a twelve (12) month period.
- 2.9.7.4 The CONTRACTOR shall monitor and manage providers' prescription patterns by, at a minimum, conducting the activities described below:
 - 2.9.7.4.1 Collaborating with the PBM to educate the MCO's contract providers regarding compliance with the State's preferred drug list (PDL) and appropriate prescribing practices; and
 - 2.9.7.4.2 Intervening with contract providers whose prescribing practices appear to be operating outside industry or peer norms as defined by TENNCARE, are non-compliant as it relates to adherence to the PDL and/or generic prescribing patterns, and/or who are failing to follow required prior authorization processes and procedures. The goal of these interventions will be to improve prescribing practices among the identified contract providers, as appropriate. Interventions shall be personal and one-on-one.

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- 2.9.7.5 At any time, upon request from TENNCARE, the CONTRACTOR shall provide assistance in educating, monitoring and intervening with providers. For example, TENNCARE may require assistance in monitoring and intervening with providers regarding prescribing patterns for narcotics.

2.9.8 Coordination of Dental Benefits

2.9.8.1 General

- 2.9.8.1.1 The CONTRACTOR is not responsible for the provision and payment of dental benefits; TENNCARE contracts with a dental benefits manager (DBM) to provide these services.

- 2.9.8.1.2 As provided in Section 2.6.1.3, the CONTRACTOR is responsible for transportation to and from dental services as well as the facility, medical and anesthesia services related to medically necessary and approved dental services that are not provided by a dentist or in a dentist's office.

- 2.9.8.1.3 The CONTRACTOR may require prior authorization for services related to dental services including the facility, anesthesia, and/or medical services related to the dental service. However, the CONTRACTOR may waive authorization of said services based upon authorization of the dental services by the dental benefits manager. The CONTRACTOR shall approve and arrange transportation to and from dental services in accordance with this Agreement, including but not limited to Attachment XIV.

2.9.8.2 Services and Responsibilities

The CONTRACTOR shall coordinate with the DBM for dental services. Coordination of dental services, at a minimum, includes establishing processes for:

- 2.9.8.2.1 Means for referral that ensures immediate access for emergency care and provision of urgent and routine care according to TennCare guidelines for specialty care (see Attachment III);
- 2.9.8.2.2 Means for the transfer of information (to include items before and after the visit);
- 2.9.8.2.3 Maintenance of confidentiality;
- 2.9.8.2.4 Resolving disputes related to prior authorizations and claims and payment issues; and
- 2.9.8.2.5 Cooperation with the DBM regarding training activities provided by the DBM.

2.9.8.3 Operating Principles

Coordinating the delivery of dental services to TennCare members is the primary responsibility of the DBM. However, the CONTRACTOR shall provide coordination assistance and shall be responsible for communicating the DBM provider services, provider relations, and/or claim coordinator contact information to all of its contract providers. With respect to specific member issues, the CONTRACTOR shall work with the DBM coordinator towards a resolution. Should systemic issues arise, the CONTRACTOR shall meet and resolve the issues with the DBM. In the event that such issues cannot be resolved, the MCO and the DBM shall meet with TENNCARE to reach final resolution of matters involved. Final resolution of system issues shall occur within ninety (90) calendar days from referral to TENNCARE.

2.9.8.4 Resolution of Requests for Prior Authorization

- 2.9.8.4.1 The CONTRACTOR agrees, and recognizes that the DBM has agreed through its contractual arrangement with the State, that any dispute concerning which party should respond to a request for prior authorization shall not cause a denial, delay, reduction, termination or suspension of any appropriate service to a TennCare enrollee. The CONTRACTOR shall

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require that its care coordinators will, in addition to their responsibilities for care coordination, deal with issues related to requests for prior authorization that require coordination between the DBM and the CONTRACTOR. The CONTRACTOR shall provide the DBM with a list of its care coordinators and telephone number(s) at which each care coordinator may be contacted. When the CONTRACTOR receives a request for prior authorization from a provider for a member and the CONTRACTOR believes the service is the responsibility of the DBM, the CONTRACTOR's care coordinator shall contact the DBM's care coordinator by the next business day after receiving the request for prior authorization. The care coordinator shall also contact the member and/or member's provider. For routine requests contact to the member or member's provider shall be made within fourteen (14) days or less of the provider's request for prior authorization and shall comply with all applicable consent decrees and court orders and TennCare rules and regulations. For urgent requests, contact shall be made immediately after receiving the request for prior authorization.

2.9.8.4.2 The CONTRACTOR shall assign staff members to serve on a coordination committee with DBM staff members. This committee shall be responsible for addressing all issues of dental care coordination. The committee will review disputes regarding clinical care and provide a clinical resolution to the dispute, subject to the terms of this Agreement. The CONTRACTOR and the DBM shall attempt in good faith to resolve any dispute and communicate the decision to the provider requesting prior authorization of a service. In the event the CONTRACTOR and the DBM cannot agree within ten (10) calendar days of the provider's request for prior authorization, the party who first received the request from the provider shall be responsible for prior authorization and payment to the contract provider within the time frames designated by TENNCARE. The CONTRACTOR and the DBM are responsible for enforcing hold harmless protection for the member. The CONTRACTOR shall ensure that any response to a request for authorization shall not exceed fourteen (14) calendar days and shall comply with all applicable consent decrees and court orders and TennCare rules and regulations.

2.9.8.5 Claim Resolution Processes

2.9.8.5.1 The CONTRACTOR shall designate one or more claims coordinators to deal with issues related to claims and payment issues that require coordination between the DBM and the CONTRACTOR. The CONTRACTOR agrees and recognizes that the DBM has agreed through its contractual arrangement with the State, to also designate one or more claims coordinators to deal with issues related to claims and payment issues that require coordination between the DBM and the CONTRACTOR. The CONTRACTOR shall provide the DBM and TennCare, with a list of its claims coordinators and telephone number(s) at which each claims coordinator may be contacted.

2.9.8.5.2 When the CONTRACTOR receives a disputed claim for payment from a provider for a member and believes care is the responsibility of the DBM, the CONTRACTOR's claims coordinators shall contact the DBM's claims coordinators within four (4) calendar days of receiving such claim for payment. If the CONTRACTOR's claims coordinator is unable to reach agreement with the DBM's claims coordinators on which party is responsible for payment of the claim, the claim shall be referred to the Claims Coordination Committee (described below) for review.

2.9.8.5.3 The CONTRACTOR shall assign claims coordinators and other representatives, as needed, to a joint CONTRACTOR/DBM Claims Coordination Committee. The number of members serving on the Claims Coordination Committee shall be determined within ten (10) calendar days of the execution of this Agreement by the mutual agreement of the DBM and MCO. The CONTRACTOR shall, at a minimum, assign two (2) representatives to the committee. The make-up of the committee may be revisited from time to time during the term of this Agreement. The Claims Coordination Committee shall review any disputes and negotiate responsibility between the CONTRACTOR and the DBM. Unless otherwise agreed, such meeting shall take place within ten (10) calendar days of receipt of the initial disputed claim or request from the provider. If resolution of the claim results in the party who assumed responsibility for authorization and payment having no liability, the other party shall

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reimburse and abide by the prior decisions of that party. Reimbursement shall be made within ten (10) calendar days of the Claims Coordination Committee's decision.

- 2.9.8.5.4 If the Claims Coordination Committee cannot reach an agreement as to the proper division of financial responsibility within ten (10) calendar days of the initial referral to the Claims Coordination Committee, said claim shall be referred to both the CONTRACTOR's and the DBM's CEO or the CEO's designee, for resolution immediately. A meeting shall be held among the CEOs or their designee(s) as soon as possible, but not longer than ten (10) calendar days after the meeting of the Claims Coordination Committee.
- 2.9.8.5.5 If the meeting between the CEOs, or their designee(s), of the DBM and MCO does not successfully resolve the dispute within ten (10) calendar days, the parties shall, within fourteen (14) calendar days of the meeting, submit a Request for Resolution of the dispute to the State or the State's designee for a decision on responsibility.
- 2.9.8.5.6 The process before the submission of a Request for Resolution, as described above, shall be completed within thirty (30) calendar days of receiving the claim for payment. In the event the parties cannot agree within thirty (30) calendar days of receiving the claim for payment, the MCO and the DBM shall be responsible for enforcing hold harmless protections for the member and the party who first received the request or claim from the provider shall be responsible for authorization and payment to the provider in accordance with the requirements of the MCO's or DBM's respective Contract/contract with the State of Tennessee. Moreover, the party that first received the request or claim from the provider shall also make written request of all requisite documentation for payment and shall provide written reasons for any denial.
- 2.9.8.5.7 The Request for Resolution shall contain a concise description of the facts regarding the dispute, the applicable Contract/contract provisions, and the position of the party making the request. A copy of the Request for Resolution shall also be delivered to the other party. The other party shall then submit a Response to the Request for Resolution within fifteen (15) calendar days of the date of the Request for Resolution. The Response shall contain the same information required of the Request for Resolution. Failure to timely file a Response or obtain an extension from the State shall be deemed a waiver of any objections to the Request for Resolution.
- 2.9.8.5.8 The State, or its designee, shall make a decision in writing regarding who is responsible for the payment of services within ten (10) calendar days of the receipt of the required information ("Decision"). The Decision may reflect a split payment responsibility that designates specific proportions to be paid by the MCO and the DBM. The Decision shall be determined solely by the State, or its designee, based on specific circumstances regarding each individual case. Within five (5) business days of receipt of the Decision, the non-successful party shall reimburse any payments made by the successful party for the services. The non-successful party shall also pay to the State, within thirty (30) calendar days of the Decision, an administrative fee equal to ten percent (10%) of the value of the claims paid, not to exceed one-thousand dollars (\$1,000), for each Request for Resolution. The amount of the DBM's or MCO's payment responsibility shall be contained in the State's Decision. These payments may be made with reservation of rights regarding any judicial resolution. If a party fails to pay the State for the party's payment responsibility as described in this Section, Section 2.9.8.5.8, within thirty (30) calendar days of the date of the State's Decision, the State may deduct amounts of the payment responsibility from any current or future amount owed the party by the State.

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2.9.8.6 Denial, Delay, Reduction, Termination or Suspension

The CONTRACTOR agrees that any claims payment dispute or request for authorization shall not cause a denial, delay, reduction, termination or suspension of any appropriate services to a TennCare member. In the event there is a claim for emergency services, the party receiving a request for authorization to treat any member shall insure that the member is treated immediately and payment for the claim shall be approved or disapproved based on the definition of emergency services specified in this Agreement.

2.9.8.7 Emergencies

Prior authorization shall not be required for emergency services prior to stabilization.

2.9.8.8 Claims Processing Requirements

All claims shall be processed in accordance with the requirements of the MCO's and DBM's respective Agreements/contracts with the State of Tennessee.

2.9.8.9 Appeal of Decision

Appeal of any Decision shall be to a court or commission of competent jurisdiction and shall not constitute a procedure under the Administrative Procedure Act, TCA 4-5-201 *et seq.* Exhaustion of the above-described process shall be required before filing of any claim or lawsuit on issues covered by this Section, Section 2.9.8.

2.9.8.10 Duties and Obligations

The existence of any dispute under this Agreement shall in no way affect the duty of the CONTRACTOR and the DBM to continue to perform their respective obligations, including their obligations established in their respective Agreements/contracts with the State pending resolution of the dispute under this Section, Section 2.9.8.10. In accordance with TCA 56-32-126(b), a provider may elect to resolve the claims payment dispute through independent review.

2.9.8.11 Confidentiality

2.9.8.11.1 The CONTRACTOR agrees, and recognizes that the DBM has agreed through its contractual arrangement with the State, to cooperate with the State to develop confidentiality guidelines that (1) meet state, federal, and other regulatory requirements; (2) meet the requirements of the professions or facilities providing care and maintaining records; and (3) meet both DBM and MCO standards. These standards shall apply to both DBM's and MCO's providers and staff. If the CONTRACTOR or DBM believes that the standards require updating, or operational changes are needed to enforce the standards, the CONTRACTOR shall meet with the DBM to resolve these issues. Such standards shall provide for the exchange of confidential e-mails to ensure the privacy of the members.

2.9.8.11.2 The DBM and MCO shall ensure all materials and information directly or indirectly identifying any current or former member which is provided to or obtained by or through the MCO's or DBM's performance of this Agreement, whether verbal, written, tape, or otherwise, shall be maintained in accordance with the standards of confidentiality of TCA 33-4-22, Section 6.22 of this Agreement, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and, unless required by applicable law, shall not be disclosed except in accordance with those requirements or to TENNCARE, and CMS, or their designees. Nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form that does not identify any current or former member or potential member.

2.9.8.12 Access to Service

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The CONTRACTOR agrees and recognizes that the DBM has agreed through its contractual arrangement with the State, to establish methods of referral which ensure immediate access to emergency care and the provision of urgent and routine care in accordance with TennCare guidelines.

2.9.9 Coordination with Medicare

2.9.9.1 The CONTRACTOR is responsible for providing medically necessary covered services to members who are also eligible for Medicare if the service is not covered by Medicare.

2.9.9.2 The CONTRACTOR shall ensure that services covered and provided pursuant to this Agreement are delivered without charge to members who are dually eligible for Medicare and Medicaid services.

2.9.9.3 The CONTRACTOR shall coordinate with Medicare payers, Medicare Advantage plans, and Medicare providers as appropriate to coordinate the care and benefits of members who are also eligible for Medicare.

2.9.10 Institutional Services and Alternatives to Institutional Services

2.9.10.1 For members enrolled in the long-term care program, the CONTRACTOR is not responsible for long-term care institutional services in a nursing facility or an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or for services provided through Home and Community Based Services (HCBS) waivers as an alternative to these institutional services. However, should the CONTRACTOR utilize nursing facility services as a cost-effective alternative to continued inpatient hospitalization, the CONTRACTOR shall be responsible for payment of such services. Further, to the extent that services available to a member through a HCBS waiver are also covered services pursuant to this Agreement, the CONTRACTOR shall be responsible for providing all medically necessary covered services. HCBS waiver services may supplement, but not supplant, medically necessary covered services. Except as noted above, long-term care services shall be provided to qualified members as described in TennCare rules and regulations through contracts between TENNCARE and appropriate providers.

2.9.10.2 The CONTRACTOR is responsible for covered services for members residing in long-term care institutions or enrolled in a HCBS waiver. For members residing in long-term care institutions, the CONTRACTOR is responsible for providing covered services that are not included in the per diem reimbursement for institutional services (e.g., prosthetics, some items of durable medical equipment, non-emergency ambulance transportation, and non-emergency transportation). Except as provided below for NEMT, for members enrolled in a HCBS waiver, the CONTRACTOR shall provide all medically necessary covered services, including covered services that may also be provided through the HCBS waiver. The HCBS waiver is the payor of last resort. However, the CONTRACTOR is not responsible for providing non-emergency medical transportation (NEMT) to any service that is being provided to the member through the HCBS waiver (see Section 2.6.1.3).

2.9.10.3 The CONTRACTOR shall coordinate the provision of covered services with services provided by institutional and HCBS waiver providers to minimize disruption and duplication of services.

2.9.10.4 The CONTRACTOR shall use its best efforts to increase the use of HCBS waivers as an alternative to long-term care institutions. This should include educating members entering or recently admitted to a long-term care institution, as well as their providers, about available HCBS waivers and coordinating with the Commission on Aging and Disability and TennCare Bureau, Long Term Care Division, as needed and as requested by TENNCARE.

2.9.11 Enrollees with Special Health Care Needs

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- 2.9.11.1 The CONTRACTOR shall implement mechanisms to assess each TennCare enrollee identified by the State as having Special Health Care Needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals. Enrollees who are dually eligible for TennCare and Medicare are exempt from this requirement. For purposes of Section 2.9.11, enrollees with Special Health Care Needs shall refer to enrollees identified through the Department of Children's Services (DCS), as described in Section 1-3 of this Agreement.
- 2.9.11.2 The CONTRACTOR shall implement procedures to share, with other MCOs, DBMs and PBMs (as necessary) serving the enrollee, the results of its identification and assessment of any enrollee with special health care needs so that those activities need not be duplicated.

2.9.12 Inter-Agency Coordination

The CONTRACTOR shall coordinate with other state and local departments and agencies to ensure that coordinated care is provided to members. This includes, but is not limited to, coordination with:

- 2.9.12.1 Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) for the purpose of interfacing with and assuring continuity of care;
- 2.9.12.2 Tennessee Department of Children's Services (DCS) for the purpose of interfacing with, assuring continuity of care, and assuring the provision of covered services to children in or transitioning out of state custody;
- 2.9.12.3 Tennessee Department of Health (DOH), for the purposes of establishing and maintaining relationships with member groups and health service providers;
- 2.9.12.4 Tennessee Department of Human Services (DHS) and DCS Protective Services Section, for the purposes of reporting and cooperating in the investigation of abuse and neglect;
- 2.9.12.5 The Division of Mental Retardation Services (DMRS), for the purposes of interfacing with and assuring continuity of care;
- 2.9.12.6 Tennessee Department of Education (DOE) and local education agencies for the purposes of coordinating educational services in compliance with the requirements of Individuals with Disabilities Education Act (IDEA) and to ensure school-based services for students with special needs are provided;
 - 2.9.12.6.1 The CONTRACTOR is responsible for the delivery of medically necessary covered services to school-aged children. MCOs are encouraged to work with school-based providers to manage the care of students with special health care needs. The State has implemented a process, referred to as TENNderCARE Connection, to facilitate notification of MCOs when a school-aged child enrolled in TennCare has an Individualized Education Plan (IEP) that identifies a need for medical services. In such cases, the school is responsible for obtaining parental consent to share the IEP with the MCO and for subsequently sending a copy of the parental consent and IEP to the MCO. The school is also responsible for clearly delineating the services on the IEP that the MCOs are to consider for payment. If a school-aged member, needing medical services, is identified by the CONTRACTOR by another means, the CONTRACTOR shall request the IEP from the appropriate school system.
 - 2.9.12.6.2 The CONTRACTOR shall designate a contact person to whom correspondence concerning children with medical services included in their IEPs will be directed. After receipt of an IEP, the CONTRACTOR shall:

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- 2.9.12.6.2.1 Either accept the IEP as indication of a medical problem and treat the IEP as a request for service or assist in making an appointment to have the child evaluated by the child's PCP or another contract provider. If the CONTRACTOR does not accept the documentation provided with the IEP as indication of a medical problem, the CONTRACTOR shall have the child re-evaluated in order to make a decision about the appropriateness of the requested service.
- 2.9.12.6.2.2 Send a copy of the IEP and any related information (e.g. action taken by the MCO in response to receipt of the IEP, action the MCO expects the PCP to take) to the PCP.
- 2.9.12.6.2.3 Notify the designated school contact of the ultimate disposition of the request (e.g. what services have been approved for the child, what arrangements have been made for service delivery) within 14 days of the CONTRACTOR's receipt of the IEP.
- 2.9.12.7 Commission on Aging and Disability and TennCare Bureau, Long Term Care Division for the purposes of coordinating care for members requiring long-term care services; and
- 2.9.12.8 Local law enforcement agencies and hospital emergency rooms for the purposes of crisis service provider relationships, and the transportation of individuals certified for further assessment for emergency psychiatric hospitalization.

2.10 SERVICES NOT COVERED

Except as authorized pursuant to Section 2.6.7 of this Agreement, the CONTRACTOR shall not pay for non-covered services as described in TennCare rules and regulations.

2.11 PROVIDER NETWORK

2.11.1 General Provisions

- 2.11.1.1 The CONTRACTOR shall provide or ensure the provision of all covered services specified in Section 2.6.1 of this Agreement. Accessibility of covered services, including geographic access and appointments and wait times shall be in accordance with the Terms and Conditions for Access which is part of the TennCare waiver and is contained herein as Attachment III, the Specialty Network Standards in Attachment IV, the Access and Availability for Behavioral Health Services in Attachment V and the requirements herein. These minimum requirements shall not release the CONTRACTOR from the requirement to provide or arrange for the provision of any medically necessary covered service required by its members, whether specified above or not.
- 2.11.1.2 The CONTRACTOR may provide covered services directly or may enter into written agreements with providers and provider subcontracting entities or organizations that will provide covered services to the members in exchange for payment by the CONTRACTOR for services rendered.
- 2.11.1.3 Should the CONTRACTOR elect to contract with providers (as opposed to using staff providers) and develop a network for the provision of covered services, the CONTRACTOR shall:
 - 2.11.1.3.1 Not execute provider agreements with providers who have been excluded from participation in the Medicare, Medicaid, and/or SCHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with the TennCare program;
 - 2.11.1.3.2 Consider: the anticipated TennCare enrollment; the expected utilization of services, taking into consideration the characteristics of specific TennCare populations included in this Agreement; the number and types of providers required to furnish TennCare services; the number of contract providers who are not accepting new members; and the geographic location of providers and TennCare members, considering distance, travel time, the means of

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- transportation ordinarily used by TennCare members, and whether the location provides physical access for members with disabilities;
- 2.11.1.3.3 Have in place, written policies and procedures for the selection and retention of providers. These policies and procedures shall not discriminate against particular providers that service high risk populations or specialize in conditions that require costly treatment;
- 2.11.1.3.4 Not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. The CONTRACTOR's ability to credential providers as well as maintain a separate network and not include any willing provider is not considered discrimination;
- 2.11.1.3.5 Give affected providers written notice if it declines to include individual or groups of providers in its network; and
- 2.11.1.3.6 Maintain all provider agreements in accordance with the provisions specified in 42 CFR 438.12, 438.214 and Section 2.12 of this Agreement.
- 2.11.1.4 Section 2.11.1.3 shall not be construed to:
- 2.11.1.4.1 Require the CONTRACTOR to contract with providers beyond the number necessary to meet the needs of its members and the access standards of this Agreement;
- 2.11.1.4.2 Preclude the CONTRACTOR from using different reimbursement amounts for different specialties or for different providers in the same specialty; or
- 2.11.1.4.3 Preclude the CONTRACTOR from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members.
- 2.11.1.5 The CONTRACTOR may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient for the following:
- 2.11.1.5.1 The member's health status, medical or behavioral health care, or treatment options, including any alternative treatment that may be self administered;
- 2.11.1.5.2 Any information the member needs in order to decide among all relevant treatment options;
- 2.11.1.5.3 The risks, benefits, and consequences of treatment or non-treatment; or
- 2.11.1.5.4 The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- 2.11.1.6 Prior to including a provider on the *Provider Enrollment File* (see Section 2.30.7.1) and/or paying a provider's claim, the CONTRACTOR shall ensure that the provider has a National Provider Identifier (NPI) Number, where applicable, and has obtained a Medicaid provider number from TENNCARE.
- 2.11.1.7 If a member requests a provider located outside the access standards, and the CONTRACTOR has an appropriate provider within the access requirements who accepts new members, it shall not be considered a violation of the access requirements for the CONTRACTOR to grant the member's request. However, in such cases the CONTRACTOR shall not be responsible for providing transportation for the member to access care from this selected provider, and the CONTRACTOR shall notify the member in writing as to whether or not the CONTRACTOR will provide transportation for the member to seek care from the requested provider.

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- 2.11.1.8 If the CONTRACTOR is unable to meet the access standards for a member, the CONTRACTOR shall provide transportation regardless of whether the member has access to transportation.
- 2.11.1.9 If the CONTRACTOR is unable to provide medically necessary covered services to a particular member using contract providers, the CONTRACTOR shall adequately and timely cover these services for that member using non-contract providers, for as long as the CONTRACTOR's provider network is unable to provide them. At such time that the required services become available within the CONTRACTOR's network and the member can be safely transferred, the CONTRACTOR may transfer the member to an appropriate contract provider as specified in Section 2.9.3.
- 2.11.1.10 The CONTRACTOR shall monitor provider compliance with applicable access requirements, including but not limited to appointment and wait times and take corrective action for failure to comply. The CONTRACTOR shall conduct surveys and office visits to monitor compliance with appointment waiting time standards and shall report findings and corrective actions to TENNCARE in accordance with Section 2.30.7.2.
- 2.11.1.11 The CONTRACTOR shall use its best efforts to contract with providers to whom the CONTRACTOR routinely refers members.
- 2.11.1.12 TENNCARE reserves the right to direct the CONTRACTOR to terminate or modify any provider agreement when TENNCARE determines it to be in the best interest of the State.
- 2.11.1.13 To demonstrate sufficient accessibility and availability of covered services, the CONTRACTOR shall comply with all reporting requirements specified in Section 2.30.7.

2.11.2 Primary Care Providers (PCPs)

- 2.11.2.1 With the exception of members dually eligible for Medicare and TennCare, the CONTRACTOR shall ensure that each member has an assigned PCP, as defined in Section 1, who is responsible for coordinating the covered services provided to the member.
- 2.11.2.2 The CONTRACTOR shall ensure that there are PCPs willing and able to provide the level of care and range of services necessary to meet the medical and behavioral health needs of its members, including those with chronic conditions. There shall be a sufficient number of PCPs who accept new TennCare members within the CONTRACTOR's service area so that the CONTRACTOR meets the Terms and Conditions for Access provided in Attachment III.
- 2.11.2.3 To the extent feasible and appropriate, the CONTRACTOR shall offer each member (other than members who are dually eligible for Medicare and TennCare) the opportunity to select a PCP.
- 2.11.2.4 The CONTRACTOR may, at its discretion, allow vulnerable populations (for example, persons with multiple disabilities, acute, or chronic conditions, as determined by the CONTRACTOR) to select their attending specialists as their PCP so long as the specialist is willing to perform all responsibilities of a PCP as defined in Section 1.
- 2.11.2.5 Children in state custody shall be assigned to a Best Practice Network Primary Care Provider as specified in Section 3 of this Agreement.
- 2.11.2.6 If a member who is not dually eligible for Medicare and TennCare fails or refuses to select a PCP from those offered within thirty (30) calendar days of enrollment, the CONTRACTOR shall assign a PCP. The CONTRACTOR may assign a PCP in less than thirty (30) calendar days if the CONTRACTOR provides the enrollee an opportunity to change PCPs upon receipt of notice of PCP assignment.
- 2.11.2.7 The CONTRACTOR shall establish policies and procedures to enable members reasonable opportunities to change PCPs. Such policies and procedures may not specify a length of time

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greater than twelve (12) months between PCP changes under normal circumstances. If the ability to change PCPs is limited, the CONTRACTOR shall include provisions for more frequent PCP changes with good cause. The policies and procedures shall include a definition of good cause as well as the procedures to request a change.

- 2.11.2.8 If a member requests assignment to a PCP located outside the distance/time requirements in Attachment III and the CONTRACTOR has PCPs available within the distance/time requirements who accept new members, it shall not be considered a violation of the access requirements for the CONTRACTOR to grant the member's request. However, in such cases the CONTRACTOR shall have no responsibility for providing transportation for the member to access care from this selected provider, and the CONTRACTOR shall notify the member in writing as to whether or not the CONTRACTOR will provide transportation for the member to seek care from the requested provider. In these cases, the CONTRACTOR shall allow the member to change assignment to a PCP within the distance/time requirements at any time if the member requests such a change.

2.11.3 Specialty Service Providers

2.11.3.1 Essential Hospital Services and Centers of Excellence

- 2.11.3.1.1 The CONTRACTOR shall demonstrate sufficient access to essential hospital services which means that, at a minimum, in each Grand Region served by the CONTRACTOR, the CONTRACTOR shall demonstrate a contractual arrangement with at least one (1) tertiary care center for each of the following:

2.11.3.1.1.1 Neonatal services;

2.11.3.1.1.2 Perinatal services;

2.11.3.1.1.3 Pediatric services;

2.11.3.1.1.4 Trauma services; and

2.11.3.1.1.5 Burn services.

- 2.11.3.1.2 The CONTRACTOR shall demonstrate sufficient access to comprehensive care for people with HIV/AIDS which means that, at a minimum, in each Grand Region in which the CONTRACTOR operates, the CONTRACTOR shall demonstrate a contractual arrangement with at least two (2) HIV/AIDS Centers of Excellence located within the CONTRACTOR's approved Grand Region(s). HIV/AIDS centers of Excellence are designated by the DOH.

2.11.3.1.3 The CONTRACTOR shall demonstrate a contractual arrangement with all Centers of Excellence for Behavioral Health located within the Grand Region(s) served by the CONTRACTOR.

2.11.3.1.4 The CONTRACTOR shall demonstrate a contractual arrangement with all Centers of Excellence for children in, or at risk of state custody, as identified by TennCare.

2.11.3.2 Physician Specialists

2.11.3.2.1 The CONTRACTOR shall establish and maintain a network of physician specialists that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical and behavioral health needs of its members (adults and children) without excessive travel requirements. This means that, at a minimum:

2.11.3.2.1.1 The CONTRACTOR has signed provider agreements with providers of the specialty types listed in Attachment IV who accept new TennCare enrollees and are available on at least a referral basis; and

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- 2.11.3.2.1.2 The CONTRACTOR is in compliance with the access and availability requirements in Attachments III, IV, and V.
- 2.11.3.3 TENNCARE Monitoring
- 2.11.3.3.1 TENNCARE will monitor CONTRACTOR compliance with specialty network standards on an ongoing basis. TENNCARE will use data from the monthly *Provider Enrollment File* required in Section 2.30.7.1, to verify compliance with the specialty network requirements. TENNCARE will use these files to confirm the CONTRACTOR has a sufficient number and distribution of physician specialists and in conjunction with MCO enrollment data to calculate member to provider ratios. TENNCARE will also periodically phone providers listed on these reports to confirm that the provider is a contract provider as reported by the CONTRACTOR. TENNCARE shall also monitor appeals data for indications that problems exist with access to specialty providers.
- 2.11.3.3.2 TENNCARE will require a corrective action plan from the CONTRACTOR when:
 - 2.11.3.3.2.1 Twenty-five percent (25%) or more of non-dual members do not have access to one or more of the physician specialties listed in Attachment IV within sixty (60) miles;
 - 2.11.3.3.2.2 Any non-dual member does not have access to one or more of the physician specialties listed in Attachment IV within ninety (90) miles; or
 - 2.11.3.3.2.3 The member to provider ratio exceeds that listed in Attachment IV.
- 2.11.3.3.3 TENNCARE will review all corrective action plans and determine, based on the actions proposed by the CONTRACTOR, appeals data, and the supply of specialty providers available to non-TennCare members, whether the corrective action plan will be accepted. Corrective action plans shall include, at a minimum, the following:
 - 2.11.3.3.3.1 The addition of contract providers to the provider network as documented on the provider enrollment file that resolves the specialty network deficiency;
 - 2.11.3.3.3.2 A list of providers with name, location, and expected date of provider agreement execution with whom the CONTRACTOR is currently negotiating a provider agreement and, if the provider becomes a contract provider would resolve the specialty network deficiency;
 - 2.11.3.3.3.3 For those deficiencies that are not resolved, a detailed account of attempts to secure an agreement with each provider that would resolve the deficiency. This shall include the provider name(s), address(es), date(s) contacted, and a detailed explanation as to why the CONTRACTOR is unable to secure an agreement, e.g., lack of provider willingness to participate in the TennCare program, provider prefers to limit access to practice, or rate requests are inconsistent with TennCare actuarial assumptions;
 - 2.11.3.3.3.4 A listing of non-contract providers, including name and location, who are being used to provide the deficient specialty provider services and the rates the CONTRACTOR is currently paying these non-contract providers;
 - 2.11.3.3.3.5 Affirmation that transportation will be provided for members to obtain services from providers who are willing to provide services to members but do not meet the specialty network standards;
 - 2.11.3.3.3.6 Documentation of how these arrangements are communicated to the member; and
 - 2.11.3.3.3.7 Documentation of how these arrangements are communicated to the PCPs.

Amendment Number 20 (cont.)

2.11.4 Special Conditions for Prenatal Care Providers

- 2.11.4.1 The CONTRACTOR shall have a sufficient number of contract providers who accept members in accordance with TennCare access standards in Attachment III so that prenatal or other medically necessary covered services are not delayed or denied to pregnant women at any time, including during their presumptive eligibility period. Additionally, the CONTRACTOR shall make services available from non-contract providers, if necessary, to provide medically necessary covered services to a woman enrolled in the CONTRACTOR's MCO.

- 2.11.4.2 Regardless of whether prenatal care is provided by a PCP, physician extender or an obstetrician who is not the member's PCP, the access standards for PCP services shall apply when determining access to prenatal care except for cases of a first prenatal care appointment for women who are past their first trimester of pregnancy on the day they are determined to be eligible for TennCare. For women who are past their first trimester of pregnancy on the day they are determined to be eligible, a first prenatal care appointment shall occur within fifteen (15) calendar days of the day they are determined to be eligible. Failure to do so shall be considered a material breach of the provider's provider agreement with the CONTRACTOR (see Sections 2.6.12 and 2.11.4).

2.11.5 Special Conditions for Behavioral Health Services

- 2.11.5.1 At the direction of the State, the CONTRACTOR shall divert new admissions to other inpatient facilities to ensure that the Regional Mental Health Institutes do not operate above their licensed capacity.

- 2.11.5.2 The CONTRACTOR shall identify, develop or enhance existing mental health and/or substance abuse inpatient and residential treatment capacity for adults and adolescents with a co-occurring mental health and substance abuse disorder.

- 2.11.5.3 The CONTRACTOR shall contract with specified crisis service teams for both adults and children as directed by TENNCARE unless the State approves the use of other crisis service providers.

2.11.6 Safety Net Providers

2.11.6.1 Federally Qualified Health Centers (FQHCs)

2.11.6.1.1 The CONTRACTOR is encouraged to contract with FQHCs and other safety net providers (e.g., rural health clinics) in the CONTRACTOR's service area to the extent possible and practical. Where FQHCs are not utilized, the CONTRACTOR shall demonstrate to DHHS, the Tennessee DHS and TENNCARE that both adequate capacity and an appropriate range of services for vulnerable populations exist to serve the expected enrollment in the CONTRACTOR's service area without contracting with FQHCs.

2.11.6.1.2 FQHC reporting information shall be submitted to TENNCARE as described in Section 2.30.7.6 of this Agreement.

2.11.6.2 Community Mental Health Agencies (CMHAs)

The CONTRACTOR is encouraged to contract with CMHAs and other behavioral health safety net providers in the CONTRACTOR's service area to the extent possible and practical. Where CMHAs are not utilized, the CONTRACTOR shall demonstrate that both adequate capacity and an appropriate range of services for all populations, but in particular SPMI/SED populations, exist to serve the expected enrollment in the CONTRACTOR's service area without contracting with CMHAs.

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2.11.6.3 Local Health Departments

The CONTRACTOR shall contract with each local health department in the Grand Region(s) served by the CONTRACTOR for the provision of TENNderCare screening services until such time as the CONTRACTOR achieves an adjusted periodic screening percentage of eighty percent (80%) or greater. Payment to local health departments shall be in accordance with Section 2.13.6.

2.11.7 **Credentialing and Other Certification**

2.11.7.1 Credentialing of Contract Providers

2.11.7.1.1 The CONTRACTOR shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.

2.11.7.1.2 The CONTRACTOR shall completely process credentialing applications within thirty (30) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement. Completely process shall mean that the CONTRACTOR shall review, approve and load approved applicants to its provider files in its claims processing system or deny the application and assure that the provider is not used by the CONTRACTOR.

2.11.7.2 Credentialing of Non-Contract Providers

2.11.7.2.1 The CONTRACTOR shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers with whom it does not contract but with whom it has an independent relationship. An independent relationship exists when the CONTRACTOR selects and directs its members to see a specific provider or group of providers.

2.11.7.2.2 The CONTRACTOR shall completely process credentialing applications within thirty (30) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed contract/agreement if applicable. Completely process shall mean that the CONTRACTOR shall review, approve and load approved applicants to its provider files in its claims processing system or deny the application and assure that the provider is not used by the CONTRACTOR.

2.11.7.3 Credentialing of Behavioral Health Entities

2.11.7.3.1 The CONTRACTOR shall ensure each behavioral health provider's service delivery site meets all applicable requirements of law and has the necessary and current license/certification/accreditation/designation approval per state requirements.

2.11.7.3.2 When individuals providing behavioral health treatment services are not required to be licensed or certified, it is the responsibility of the CONTRACTOR to ensure, based on applicable state licensure rules and/or programs standards, that they are appropriately educated, trained, qualified, and competent to perform their job responsibilities.

2.11.7.4 Compliance with the Clinical Laboratory Improvement Amendments (CLIA) of 1988

The CONTRACTOR shall require that all laboratory testing sites providing services under this Agreement have either a current CLIA certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver will provide only the types of tests permitted under the terms of their waiver. Laboratories with certificate of registration may perform a full range of laboratory tests. The CONTRACTOR shall comply with the provisions of CLIA 1988.

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2.11.7.5 Weight Watchers Centers or Other Weight Management Program

The CONTRACTOR is not required to credential Weight Watchers centers(s) or another weight management program used as a cost effective alternative service pursuant to Section 2.8.8 of this Agreement.

2.11.8 **Network Notice Requirements**

2.11.8.1 Member Notification

All member notices required shall be written using the appropriate notice template provided by TENNCARE and shall include all notice content requirements specified in applicable state and federal law, TennCare rules and regulations, and all court orders and consent decrees governing notice and appeal procedures, as they become effective.

2.11.8.1.1 *Change in PCP*

The CONTRACTOR shall immediately provide written notice to a member when the CONTRACTOR changes the member's PCP. The notice shall be issued in advance of the PCP change when possible or as soon as the CONTRACTOR becomes aware of the circumstances necessitating a PCP change.

2.11.8.1.2 *PCP Termination*

If a PCP ceases participation in the CONTRACTOR's MCO, the CONTRACTOR shall provide written notice as soon as possible, but no less than thirty (30) calendar days prior to the effective date of the termination and no more than fifteen (15) calendar days after receipt or issuance of the termination notice, to each member who has chosen or been assigned to that provider as their PCP. The requirement to provide notice thirty (30) calendar days prior to the effective date of termination shall be waived in instances where a provider becomes physically unable to care for members due to illness, a provider dies, the provider fails to provide thirty (30) calendar days advance notice to the CONTRACTOR, the provider moves from the service area and fails to notify the CONTRACTOR or a provider fails credentialing, and instead shall be made immediately upon the CONTRACTOR becoming aware of the circumstances.

2.11.8.1.3 *Providers Providing Ongoing Treatment Termination*

If a member is in a prior authorized ongoing course of treatment with any other contract provider who becomes unavailable to continue to provide services to such member and the CONTRACTOR is aware of such ongoing course of treatment, the CONTRACTOR shall provide written notice to each member as soon as possible but no less than thirty (30) calendar days prior to the effective date of the termination and no more than fifteen (15) calendar days after receipt or issuance of the termination notice. The requirement to provide notice thirty (30) calendar days prior to the effective date of termination shall be waived in instances where a provider becomes physically unable to care for members due to illness, a provider dies, the provider fails to provide thirty (30) calendar days advance notice to the CONTRACTOR, the provider moves from the service area and fails to notify the CONTRACTOR or a provider fails credentialing, and instead shall be made immediately upon the CONTRACTOR becoming aware of the circumstances.

2.11.8.1.4 *Non-PCP Provider Termination*

If a non-PCP provider, including but not limited to a specialist or hospital, ceases participation in the CONTRACTOR's MCO, the CONTRACTOR shall provide written notice to members who have been patients of the non-PCP provider. Notice shall be issued no less than thirty (30) days prior to the effective date of the termination of the non-PCP provider when possible or immediately upon the CONTRACTOR becoming aware of the termination.

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2.11.8.1.5 *Network Deficiency*

Upon notification from TENNCARE that a corrective action plan designed to remedy a network deficiency has not been accepted, the CONTRACTOR shall immediately provide written notice to members living in the affected area of a provider shortage in the CONTRACTOR's network.

2.11.8.2 TENNCARE Notification

2.11.8.2.1 *Subcontractor Termination*

When a subcontract that relates to the provision of services to members or claims processing is being terminated between the CONTRACTOR and a subcontractor, the CONTRACTOR shall give at least thirty (30) calendar days prior written notice of the termination to TENNCARE and TDCI. Said notices shall include, at a minimum: a CONTRACTOR's intent to change to a new subcontractor for the provision of said services; an effective date for termination and/or change; and any other pertinent information that may be needed to access services. In addition to prior written notice, the CONTRACTOR shall also provide a transition plan to TENNCARE within fifteen (15) calendar days, which shall include, at a minimum, information regarding how prior authorization requests will be handled during and after the transition and how continuity of care will be maintained for the members.

2.11.8.2.2 *Hospital Termination*

Termination of the CONTRACTOR's provider agreement with any hospital, whether or not the termination is initiated by the hospital or by the CONTRACTOR, shall be reported by the CONTRACTOR in writing to the TENNCARE no less than thirty (30) calendar days prior to the effective date of the termination.

2.11.8.2.3 *Other Provider Terminations*

2.11.8.2.3.1 The CONTRACTOR shall notify TENNCARE of any provider termination and shall submit a copy of one of the actual member notices mailed as well as an electronic listing in Excel format that includes the provider's name, TennCare provider identification number, and NPI number and identifies each member to whom a notice was sent within five (5) business days of the date the member notice was sent as required in Section 2.11.8.1. In addition to the member notice and electronic listing, documentation from the CONTRACTOR's mail room or outside vendor indicating the quantity and date member notices were mailed shall be sent to TENNCARE as proof of compliance with the member notification requirements. The CONTRACTOR shall maintain a copy of the actual notice on-site and forward a copy of the notices upon request from TENNCARE. If the termination was initiated by the provider, the notice to TENNCARE shall include a copy of the provider's notification to the CONTRACTOR.

2.11.8.2.3.2 If termination of the CONTRACTOR's provider agreement with any PCP or physician group or clinic, whether or not the termination is initiated by the provider or by the CONTRACTOR, places the CONTRACTOR out of compliance with Section 2.11 and Attachments III, IV and V, such termination shall be reported by the CONTRACTOR in writing to TENNCARE, in the standard format provided by TENNCARE to demonstrate compliance with provider network and access requirements, within five (5) business days of the date that the agreement has been terminated.

2.12 PROVIDER AGREEMENTS

2.12.1 Provider agreements, as defined in Section 1 of this Agreement, shall be administered in accordance with this Agreement and shall contain all of the items listed in this Section 2.12.

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- 2.12.2 All template provider agreements and revisions thereto must be approved in writing in advance by TDCI in accordance with statutes regarding the approval of a certificate of authority (COA) and any material modifications thereof.
- 2.12.3 The CONTRACTOR shall revise provider agreements as directed by TENNCARE.
- 2.12.4 All single case agreements shall be reported to TENNCARE in accordance with Section 2.30.8; however, prior approval will not be required unless TENNCARE determines, upon review of said reports, that it appears single case agreements are being used to circumvent the provider agreement review and approval process.
- 2.12.5 No provider agreement terminates or reduces the legal responsibility of the CONTRACTOR to TENNCARE to ensure that all activities under this Agreement are carried out. It shall be the responsibility of the CONTRACTOR to provide all necessary training and information to providers to ensure satisfaction of all CONTRACTOR responsibilities as specified in this Agreement.
- 2.12.6 The CONTRACTOR shall not execute provider agreements with providers who have been excluded from participation in the Medicare, Medicaid, and/or SCHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with the TennCare program.
- 2.12.7 All provider agreements executed by the CONTRACTOR, and all provider agreements executed by subcontracting entities or organizations, shall, at a minimum, meet the following requirements:
 - 2.12.7.1 Be in writing. All new provider agreements and existing provider agreements as they are renewed, shall include a signature page which contains CONTRACTOR and provider names which are typed or legibly written, provider company with titles, and dated signatures of all appropriate parties;
 - 2.12.7.2 Specify the effective dates of the provider agreement;
 - 2.12.7.3 Specify that the provider agreement and its attachments contain all the terms and conditions agreed upon by the parties;
 - 2.12.7.4 Assure that the provider shall not enter into any subsequent agreements or subcontracts for any of the work contemplated under the provider agreement without the prior written approval of the CONTRACTOR;
 - 2.12.7.5 Identify the population covered by the provider agreement;
 - 2.12.7.6 Specify that the provider may not refuse to provide covered medically necessary or covered preventive services to a child under the age of twenty-one (21) or a TennCare Medicaid patient under this Agreement for non-medical reasons. However, the provider shall not be required to accept or continue treatment of a patient with whom the provider feels he/she cannot establish and/or maintain a professional relationship;
 - 2.12.7.7 Specify the functions and/or services to be provided by the provider and assure that the functions and/or services to be provided are within the scope of his/her professional/technical practice;
 - 2.12.7.8 Specify the amount, duration and scope of services to be provided by the provider and inform the provider of TennCare non-covered services as described in Section 2.10 of this Agreement and the TennCare rules and regulations;
 - 2.12.7.9 Provide that emergency services be rendered without the requirement of prior authorization of any kind;
 - 2.12.7.10 Specify that unreasonable delay in providing care to a pregnant member seeking prenatal care shall be considered a material breach of the provider's agreement with the CONTRACTOR

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- and include the definition of unreasonable delay as described in Section 2.6.12 of this Agreement;
- 2.12.7.11 If the provider performs laboratory services, require the provider to meet all applicable requirements of the Clinical Laboratory Improvement Amendments (CLIA) of 1988;
- 2.12.7.12 Require that an adequate record system be maintained and that all records be maintained for five (5) years from the close of the provider agreement (behavioral health records shall be maintained at the provider level for ten (10) years after the termination of the provider agreement pursuant to TCA 33-3-101) or retained until all evaluations, audits, reviews or investigations or prosecutions are completed for recording enrollee services, servicing providers, charges, dates and all other commonly accepted information elements for services rendered to enrollees pursuant to the provider agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the provider agreement and administrative, civil or criminal investigations and prosecutions);
- 2.12.7.13 Include a statement that as a condition of participation in TennCare, enrollees shall give TENNCARE, the Office of the Comptroller of the Treasury, and any health oversight agency, such as OIG, TBI MFCU, DHHS Office of Inspector General (DHHS OIG), and DOJ, and any other authorized state or federal agency, access to their records. Said records shall be made available and furnished immediately upon request by the provider for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring as well as for administrative, civil and criminal investigations or prosecutions upon the request of an authorized representative of the CONTRACTOR, TENNCARE or authorized federal, state and Office of the Comptroller of the Treasury personnel, including, but not limited to, the OIG, the TBI MFCU, the DHHS OIG and the DOJ;
- 2.12.7.14 Include medical records requirements found in Section 2.24.4 of this Agreement;
- 2.12.7.15 Contain the language described in Section 2.25.6 of this Agreement regarding Audit Requirements and Section 2.25.5 of this Agreement regarding Availability of Records;
- 2.12.7.16 Provide that TENNCARE, DHHS OIG, Office of the Comptroller of the Treasury, OIG, TBI MFCU, and DOJ, as well as any authorized state or federal agency or entity shall have the right to evaluate through inspection, evaluation, review or request, whether announced or unannounced, or other means any records pertinent to this Agreement including, but not limited to medical records, billing records, financial records, and/or any records related to services rendered, quality, appropriateness and timeliness of services and/or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution and such evaluation, inspection, review or request, and when performed or requested, shall be performed with the immediate cooperation of the provider. Upon request, the provider shall assist in such reviews including the provision of complete copies of medical records. Include a statement that HIPAA does not bar disclosure of protected health information (PHI) to health oversight agencies, including, but not limited to, OIG, TBI MFCU, DHHS OIG and DOJ. Provide that any authorized state or federal agency or entity, including, but not limited to TENNCARE, OIG, TBI MFCU, DHHS OIG, DOJ, Office of the Comptroller of the Treasury, may use these records and information for administrative, civil or criminal investigations and prosecutions;
- 2.12.7.17 Provide for monitoring, whether announced or unannounced, of services rendered to members;
- 2.12.7.18 Provide for the participation and cooperation in any internal and external QM/QI, utilization review, peer review and/or appeal procedures established by the CONTRACTOR and/or TENNCARE;
- 2.12.7.19 Specify CONTRACTOR's responsibilities under this Agreement and its agreement with the provider, including but not limited to, provision of a copy of the member handbook and

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- provider handbook whether via web site or otherwise and requirement that the CONTRACTOR notice a provider of denied authorizations;
- 2.12.7.20 Specify that the CONTRACTOR shall monitor the quality of services delivered under the provider agreement and initiate corrective action where necessary to improve quality of care, in accordance with that level of medical or behavioral health care which is recognized as acceptable professional practice in the respective community in which the provider practices and/or the standards established by TENNCARE;
- 2.12.7.21 Require that the provider comply with corrective action plans initiated by the CONTRACTOR;
- 2.12.7.22 Provide for the timely submission of all reports and clinical information required by the CONTRACTOR;
- 2.12.7.23 Provide the name and address of the official payee to whom payment shall be made;
- 2.12.7.24 Make full disclosure of the method and amount of compensation or other consideration to be received from the CONTRACTOR;
- 2.12.7.25 Provide for prompt submission of information needed to make payment. Specify that a provider shall have one hundred twenty (120) calendar days from the date of rendering a health care service to file a claim with the CONTRACTOR except in situations regarding coordination of benefits or subrogation in which case the provider is pursuing payment from a third party or if an enrollee is enrolled in the MCO with a retroactive eligibility date. In situations of third party benefits, the maximum time frames for filing a claim shall begin on the date that the third party documented resolution of the claim. In situations of enrollment in the CONTRACTOR's MCO with a retroactive eligibility date, the time frames for filing a claim shall begin on the date that the CONTRACTOR receives notification from TENNCARE of the enrollee's eligibility/enrollment;
- 2.12.7.26 Provide for payment to the provider upon receipt of a clean claim properly submitted by the provider within the required time frames as specified in TCA 56-32-126 and Section 2.22.4 of this Agreement;
- 2.12.7.27 Specify the provider shall accept payment or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payer) plus the amount of any applicable TennCare cost sharing responsibilities, as payment in full for covered services provided and shall not solicit or accept any surety or guarantee of payment from the enrollee in excess of the amount of applicable TennCare cost sharing responsibilities. Enrollee shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the enrollee being served;
- 2.12.7.28 Specify that in the event that TENNCARE deems the CONTRACTOR unable to timely process and reimburse claims and requires the CONTRACTOR to submit provider claims for reimbursement to an alternate claims processor to ensure timely reimbursement, the provider shall agree to accept reimbursement at the CONTRACTOR's contracted reimbursement rate or the rate established by TENNCARE, whichever is greater;
- 2.12.7.29 Specify the provider's responsibilities and prohibited activities regarding cost sharing as provided in Section 2.6.15 of this Agreement;
- 2.12.7.30 Specify the provider's responsibilities regarding third party liability (TPL);
- 2.12.7.31 For those agreements where the provider is compensated via a capitation arrangement, language which requires:

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- 2.12.7.31.1 That if a provider becomes aware for any reason that he or she is not entitled to a capitation payment for a particular enrollee (a patient dies, for example), the provider shall immediately notify both the CONTRACTOR and TENNCARE by certified mail, return receipt requested; and
- 2.12.7.31.2 The provider shall submit utilization or encounter data as specified by the CONTRACTOR so as to ensure the CONTRACTOR's ability to submit encounter data to TENNCARE that meets the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims;
- 2.12.7.32 Require the provider to comply with fraud and abuse requirements described in Section 2.20 of this Agreement;
- 2.12.7.33 As a condition of reimbursement for global procedure codes for obstetric care, the provider shall submit utilization or encounter data as specified by the CONTRACTOR in a timely manner to support the individual services provided;
- 2.12.7.34 Require the provider to secure all necessary liability and malpractice insurance coverage as is necessary to adequately protect the CONTRACTOR's members and the CONTRACTOR under the provider agreement. The provider shall maintain such insurance coverage at all times during the provider agreement and upon execution of the provider agreement furnish the CONTRACTOR with written verification of the existence of such coverage;
- 2.12.7.35 Specify both the CONTRACTOR and the provider agree to recognize and abide by all state and federal laws, regulations and guidelines applicable to the CONTRACTOR and the provider. Provide that the agreement incorporates by reference all applicable federal law and state laws, TennCare rules and regulations, consent decrees or court orders, and revisions of such laws, regulations, consent decrees or court orders shall automatically be incorporated into the provider agreement, as they become effective;
- 2.12.7.36 Specify procedures and criteria for any alterations, variations, modifications, waivers, extension of the provider agreement termination date, or early termination of the agreement and specify the terms of such change. If provision does not require amendments be valid only when reduced to writing, duly signed and attached to the original of the provider agreement, then the terms shall include provisions allowing at least thirty (30) calendar days to give notice of rejection and requiring that receipt of notification of amendments be documented (e.g., certified mail, facsimile, hand-delivered receipt, etc);
- 2.12.7.37 Specify that TENNCARE reserves the right to direct the CONTRACTOR to terminate or modify the provider agreement when TENNCARE determines it to be in the best interest of the State.
- 2.12.7.38 Specify that both parties recognize that in the event of termination of this Agreement between the CONTRACTOR and TENNCARE for any of the reasons described in Section 6.2 of this Agreement, the provider shall immediately make available, to TENNCARE, or its designated representative, in a usable form, any or all records, whether medical or financial, related to the provider's activities undertaken pursuant to the CONTRACTOR/provider agreement. The provision of such records shall be at no expense to TENNCARE;
- 2.12.7.39 Specify that the TennCare Provider Independent Review of Disputed Claims process shall be available to providers to resolve claims denied in whole or in part by the CONTRACTOR as provided at TCA 56-32-126(b);
- 2.12.7.40 Include a Conflict of Interest clause as stated in Section 6.7 of this Agreement, Gratuities clause as stated in Section 6.11 of this Agreement, and Lobbying clause as stated in Section 6.12 of this Agreement between the CONTRACTOR and TENNCARE;

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- 2.12.7.41 Specify that at all times during the term of the agreement, the provider shall indemnify and hold TENNCARE harmless from all claims, losses, or suits relating to activities undertaken pursuant to the Agreement between TENNCARE and the CONTRACTOR. This indemnification may be accomplished by incorporating Section 5.20 of the TENNCARE/CONTRACTOR Agreement in its entirety in the provider agreement or by use of other language developed by the CONTRACTOR and approved in writing by TENNCARE;
- 2.12.7.42 Require safeguarding of information about enrollees according to applicable state and federal laws and regulations and as described in Sections 2.27 and 5.22 of this Agreement;
- 2.12.7.43 Specify provider actions to improve patient safety and quality;
- 2.12.7.44 Provide general and targeted education to providers regarding emergency appeals, including when an emergency appeal is appropriate, and procedures for providing written certification thereof, and specify that the provider shall comply with the appeal process, including but not limited to the following:
 - 2.12.7.44.1 Assist an enrollee by providing appeal forms and contact information including the appropriate address, telephone number and/or fax number for submitting appeals for state level review; and
 - 2.12.7.44.2 Require in advance, that providers seek prior authorization, when they feel they cannot order a drug on the TennCare PDL as well as taking the initiative to seek prior authorization or change or cancel the prescription when contacted by an enrollee or pharmacy regarding denial of a pharmacy service due to system edits (e.g., therapeutic duplication, etc.).
- 2.12.7.45 Require the provider to coordinate with the TennCare PBM regarding authorization and payment for pharmacy services;
- 2.12.7.46 Specify any liquidated damages, sanctions or reductions in payment that the CONTRACTOR may assess on the provider for specific failures to comply with contractual and/or credentialing requirements. This shall include, but may not be limited to a provider's failure or refusal to respond to the CONTRACTOR's request for information, the request to provide medical records, credentialing information, etc.; at the CONTRACTOR's discretion or a directive by TENNCARE, the CONTRACTOR shall impose financial consequences against the provider as appropriate;
- 2.12.7.47 Require that the provider display notices of the enrollee's right to appeal adverse action affecting services in public areas of their facility(s) in accordance with TennCare rules and regulations, subsequent amendments, or any and all consent decrees and court orders. The CONTRACTOR shall ensure that providers have a correct and adequate supply of public notices;
- 2.12.7.48 Include language which informs providers of the package of benefits that TENNderCare offers and which requires providers to make treatment decisions based upon children's individual medical and behavioral health needs. TENNderCare requirements are contained in Section 2.6.13 of this Agreement. All provider agreements shall contain language that references the TENNderCare requirements in this Agreement between TENNCARE and the CONTRACTOR, and the provider agreement shall either physically incorporate these sections of the Agreement or include language to require that these sections be furnished to the provider upon request;
- 2.12.7.49 Include a provision which states that providers are not permitted to encourage or suggest, in any way, that TennCare children be placed into state custody in order to receive medical or behavioral services covered by TENNCARE;
- 2.12.7.50 Require that providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees;

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- 2.12.7.51 Specify that the provider have written procedures for the provision of language interpretation and translation services for any enrollee who needs such services, including but not limited to, enrollees with Limited English Proficiency;
 - 2.12.7.52 Require the provider to comply and submit to the CONTRACTOR disclosure of information in accordance with the requirements specified in 42 CFR Part 455, Subpart B; and
 - 2.12.7.53 Require providers to screen their employees and contractors initially and on an ongoing monthly basis to determine whether any of them have been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded. The provider shall be required to immediately report to the CONTRACTOR any exclusion information discovered. The provider shall be informed that civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to TennCare members;
 - 2.12.7.54 Require that if any requirement in the provider agreement is determined by TENNCARE to conflict with the Agreement between TENNCARE and the CONTRACTOR, such requirement shall be null and void and all other provisions shall remain in full force and effect.
- 2.12.8 No other terms or conditions agreed to by the CONTRACTOR and the provider shall negate or supersede the requirements listed in 2.12.7 above.
 - 2.12.9 The provider agreement with a local health department (see Section 2.11.6.3) shall meet the minimum requirements specified above and shall also specify for the purpose of TENNderCare screening services: (1) that the local health department agrees to submit encounter data timely to the CONTRACTOR; (2) that the CONTRACTOR agrees to timely process claims for services in accordance with Section 2.22.4; (3) that the local health department may terminate the agreement for cause with thirty (30) days advance notice; and (4) that the CONTRACTOR agrees prior authorization shall not be required for the provision of TENNderCare screening services.
 - 2.12.10 The provider agreement for CRG/TPG assessments shall meet the minimum requirements specified above and shall also specify that all CRG/TRG assessments detailed in Section 2.6.5.9 are completed by State-certified raters and that the assessments are completed within the specified time frames. The rater certification process shall include completing the CRG/TPG assessments training and passing the State rater competency examination, scored only by State-certified trainers.

2.13 PROVIDER AND SUBCONTRACTOR PAYMENTS

2.13.1 General

- 2.13.1.1 Maximum Allowable Rates. Providers shall be paid according to BlueCare policies and procedures and reimbursement rates in effect as of March 1, 2001, unless otherwise directed by TennCare with the following exceptions:
 - 2.13.1.1.1 The payment rate for an initial EPSDT screening conducted by a Best Practice Network Primary Care Provider for a child in state custody shall be at the rate specified in Section 2.13.2.1.
 - 2.13.1.1.2 The payment rate for all other preventive health services specified below for children (under age 21) may be increased up to 85% of the 2001 Medicare fee-schedule, unless otherwise specified by TENNCARE.

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- 2.13.1.1.2.1 The CONTRACTOR shall make an enhanced payment, defined as eighty-five percent (85%) of the 2001 Medicare fee-schedule or the BlueCare reimbursement rates in effect as of March 1, 2001, whichever is greater, to Primary Care Providers for the provision of the following preventive medical services identified by the CPT procedure codes listed below, when billed for children less than 21 years of age. Payment rates for services reimbursed as a percentage of average wholesale price shall be adjusted in accordance with Section 2.13.1.1.4. of this Agreement.

Office Visits

NEW PATIENT	ESTABLISHED PATIENT
99431 – History and Evaluation of Normal newborn	99391 – Periodic reevaluation
99432 – Normal Newborn care other than a hospital or birthing setting	99392 – age 1 through 4 years
99381 – Initial evaluation	99393 – age 5 through 11 years
99382 – age 1 through 4 years	99394 – age 12 through 17 years
99383 – age 5 through 11 years	99395 – age 18 through 39 years
99384 – age 12 through 17 years	
99385 – age 18 through 39 years	

Counseling and Risk Factor Reduction Intervention

INDIVIDUAL	GROUP
99401 – approximately 15 minutes	99411 – approximately 30 minutes
99402 – approximately 30 minutes	99412 – approximately 60 minutes
99403 – approximately 45 minutes	
99404 – approximately 60 minutes	

Other Preventive Services

99420	Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal)
90700 – 90744	Immunizations
92551	Screening test, pure tone, air only (Audiologic function)
92552	Pure tone audiometry (threshold); air only

- 2.13.1.1.3 The payment rate for all services that are reimbursed as a percentage of average wholesale prices shall be adjusted with fluctuations in the average wholesale price. However, the “percentage” applied to determine the payment amount shall be equivalent to the percentage applied for BlueCare as of March 1, 2001.
- 2.13.1.1.4 The initial utilization management and referral processes and requirements impacting provider reimbursement shall be those in effect for BlueCare and TennCare Select as of July 1, 2001. However, the State reserves the right to require the CONTRACTOR to modify these processes and requirements. The CONTRACTOR shall have sixty (60) days from the date of request to implement requested modifications.
- 2.13.1.1.5 If there is a network deficiency that necessitates additional funding to remedy, the CONTRACTOR shall attempt to negotiate a reasonable rate on behalf of the State prior to recommending an increase in reimbursement rates. Once the negotiations are concluded, the CONTRACTOR shall submit a recommendation to the State in writing with supporting documentation justifying an increase in reimbursement rates. The CONTRACTOR may not implement a recommended change until receipt of written approval from TennCare.

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- 2.13.1.2 Annual Review of Maximum Allowable Rates. The maximum allowable reimbursement rates shall be reviewed on an annual basis.
- 2.13.1.3 All reimbursement paid by the CONTRACTOR to providers and amounts paid by the CONTRACTOR to any other entity is subject to audit by the State. The CONTRACTOR shall allow for periodic review of records to ensure that all discounts, special pricing considerations and financial incentives have accrued to the State and that all costs incurred are in accordance with this Agreement. The CONTRACTOR shall provide the auditor access to all information necessary to perform the examination.
- 2.13.1.4 The claims payment amount shall not include payment for enrollee cost-sharing amounts.
- 2.13.1.5 The CONTRACTOR shall require, as a condition of payment, that the provider (contract or non-contract provider) accept the amount paid by the CONTRACTOR or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payer) plus any applicable amount of TennCare cost sharing responsibilities due from the enrollee as payment in full for the service.
- 2.13.1.6 If the CONTRACTOR is required to reimburse a non-contract provider pursuant to this Agreement, and the CONTRACTOR's payment to a non-contract provider is less than it would have been for a contract provider, and the provider contests the payment amount, the CONTRACTOR shall notify the non-contract provider that the provider may initiate the independent review procedures in accordance with TCA 56-32-126, including but not limited to reconsideration by the CONTRACTOR.
- 2.13.1.7 The CONTRACTOR shall ensure that the member is held harmless by the provider for the costs of medically necessary covered services except for applicable TennCare cost sharing amounts described in Section 2.6.15 and in Attachment XII of this Agreement.
- 2.13.1.8 The CONTRACTOR shall ensure that payments are not issued to providers that have not obtained a Tennessee Medicaid provider number or for which disclosure requirements have not been obtained by the CONTRACTOR in accordance with 42 CFR 455.100 through 106 and Section 2.12.7.52 of this Agreement.
- 2.13.1.9 Except where required by the Contractor's Contract with TennCare or by applicable federal or state law, rule or regulation, the CONTRACTOR shall not make payment for the cost of any medical care provided prior to the effective date of eligibility or after the termination date in the CONTRACTOR's plan. The CONTRACTOR shall make payment for the cost of any covered services obtained on or after 12:01 a.m. on the effective date of eligibility in the CONTRACTOR's plan.
- 2.13.1.10 The CONTRACTOR shall prepare checks for payment of providers for the provision of covered services on a weekly basis, unless an alternative payment schedule is approved by TENNCARE.
 - 2.13.1.10.1 The CONTRACTOR shall notify the State of the amount to be paid in a mutually acceptable form and substance at least 72 hours in advance of distribution of provider checks.
 - 2.13.1.10.2 The State shall release funds in the amount to be paid to providers to the CONTRACTOR. Funds shall be released within 72 hours of receipt of notice.
 - 2.13.1.10.3 The CONTRACTOR shall release payments to providers within 24 hours of receipt of funds from the State.
 - 2.13.1.10.4 The amount to be paid shall be reduced by the amount of third party recoveries captured in the claims processing system. The State shall release funds in the amount to be paid to providers to the CONTRACTOR.
- 2.13.1.11 For each request related to payments to providers through the CONTRACTOR's claims processing system, the CONTRACTOR shall provide a claims data extract in a format and

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media described by TENNCARE to support the payments released to providers by no later than seven (7) calendar days after the CONTRACTOR's request of the funds.

2.13.1.12 The CONTRACTOR shall provide a reconciliation for the total paid amounts between the funds released for payment to providers, the supporting claims data extract, and the encounter data submissions for the relevant adjudication cycle. The reconciliation should be submitted within seven (7) days of the claims data extract.

2.13.1.13 Upon notification by TENNCARE, funds released to the CONTRACTOR for purposes of provider payments shall be made based on the CONTRACTOR's encounter data. TENNCARE shall implement this process by initially making payments based on all encounters and providing the CONTRACTOR an error report of unacceptable encounter records. The final phase of implementation shall result in TENNCARE releasing funds based on clean encounters only. Once TENNCARE releases funds based solely on clean encounter data, the CONTRACTOR will no longer be required to submit the claims data extract. The reconciliation and check register must continue to be submitted on a weekly basis for the previous weeks check release.

2.13.2 Best Practice Network Requirements

2.13.2.1 Enhanced Initial EPSDT Screening Rate

The CONTRACTOR shall make an enhanced payment to Best Practice Network Primary Care Providers and Health Departments for the initial EPSDT examination for children in state custody, when all seven (7) components of the exam have been completed. The seven components shall include: (1) A comprehensive health and development history to include both physical and mental health; (2) Comprehensive unclothed physical exam; (3) Appropriate vision and hearing assessment; (4) Laboratory testes appropriate for age and risk; (5) Dental screening and referral beginning at age 3; (6) Immunizations; (7) Health education (anticipatory guidance).

2.13.2.1.1 The procedure codes to be utilized when billing for the initial EPSDT exam are specified below. This language does not preclude the BPN-PCP from billing for other services separately, consistent with the CONTRACTOR's procedures for claims processing (e.g., lab). It is the responsibility of the CONTRACTOR to include in its Best Practice Network provider agreements a requirement that all seven components of the EPSDT exam are completed when an enhanced payment is made through a medical chart review. The CONTRACTOR should educate providers to document any barriers to completing all seven components (e.g. past history not available). The enhanced payment rate for the initial EPSDT screening exam shall be ninety-five percent (95%) of the 2001 Medicare fee-schedule. Effective December 1, 2001, the enhanced fee schedule shall be 100% of the 2001 Medicare fee schedule unless otherwise specified by TENNCARE.

NEW PATIENT	ESTABLISHED PATIENT
99431 – History and Examination of Normal Newborn	99391 – Periodic reevaluation
99432 – Normal Newborn care other than a hospital or birthing setting	99392 – age 1 through 4 years
99381 – Initial evaluation	99393 – age 5 through 11 years
99382 – age 1 through 4 years	99394 – age 12 through 17 years
99383 – age 5 through 11 years	99395 – age 18 through 39 years
99384 – age 12 through 17 years	
99385 – age 18 through 39 years	

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If the BPN-PCP submits a claim with a procedure code for an established patient, the CONTRACTOR may only reimburse the provider at the enhanced payment rate if the claim is for the initial EPSDT exam upon placement in state custody. If the CONTRACTOR directs BPN-PCPs to only bill the initial EPSDT exam with the New Patient procedure code series identified above, the CONTRACTOR must notify and provide appropriate training to the provider and provider's billing staff to implement this billing procedure

2.13.2.2 Case Management

In exchange for performing additional care coordination and case management functions as specified in Section 3 of this Agreement, the CONTRACTOR shall pay Best Practice Network Primary Care Providers a case management fee of \$10 per member per month.

2.13.3 **All Covered Services**

2.13.3.1 Except as provided in Sections 2.13.2.2 and 2.13.2.3 below, the CONTRACTOR shall not reimburse providers based on a percentage of billed charges.

2.13.3.2 The CONTRACTOR may, at its discretion, pay a percentage of billed charges for covered services for which there is no Medicare reimbursement methodology.

2.13.3.3 As part of a stop-loss arrangement with a provider, the CONTRACTOR may, at its discretion, pay the provider a percentage of billed charges for claims that exceed the applicable stop-loss threshold.

2.13.4 **Hospice**

Hospice services shall be provided and reimbursed in accordance with state and federal requirements, including but not limited to the following:

2.13.4.1 Rates shall be no less than the federally established Medicaid hospice rates (updated each federal fiscal year (FFY)), adjusted by area wage adjustments for the categories described by CMS;

2.13.4.2 The rates described above shall be subject to the annual cap for Medicaid Hospice rates as provided annually by CMS; and

2.13.4.3 If a Medicaid hospice patient resides in a nursing facility (NF), the CONTRACTOR shall pay an amount equal to at least 95 percent of the prevailing NF room and board rate to the hospice provider (not subject to the annual cap for Medicaid Hospice rates).

2.13.5 **Behavioral Health Crisis Service Teams**

2.13.5.1 The CONTRACTOR shall reimburse crisis mobile teams for their intervention services. TennCare may require the CONTRACTOR to reimburse crisis mobile teams on a monthly basis at a rate to be determined and set by the State.

2.13.5.2 The CONTRACTOR shall negotiate rates for crisis respite and crisis stabilization services.

2.13.6 **Local Health Departments**

2.13.6.1 The CONTRACTOR shall reimburse contracted local health departments (see Sections 2.11.6.3 and 2.12.9) for TENNderCare screenings to members under age twenty-one (21) at the following rates, unless specified otherwise by TENNCARE. Although the codes include preventive visits for individuals twenty-one (21) and older, this Section only requires the CONTRACTOR to pay local health departments for the specified visits for members under age twenty-one (21).

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Preventive Visits	85% of 2001 Medicare
99381 New pt. Up to 1 yr.	\$80.33
99382 New pt. 1- 4 yrs.	\$88.06
99383 New pt. 5 - 11yrs.	\$86.60
99384 New pt. 12 - 17yrs.	\$95.39
99385 New pt. 18 - 39 yrs.	\$93.93
99391 Estab. pt. Up to 1 yr.	\$63.04
99392 Estab. pt. 1 - 4 yrs.	\$71.55
99393 Estab. pt. 5 - 11yrs.	\$70.96
99394 Estab. pt. 12 - 17yrs.	\$79.57
99395 Estab. pt. 18 - 39 yrs.	\$78.99

2.13.6.2 TENNCARE may conduct an audit of the CONTRACTOR’s reimbursement methodology and related processes on an annual basis to verify compliance with this requirement. In addition, the Local Health Department may initiate the independent review procedure at any time it believes the CONTRACTOR’s payment is not the required reimbursement rate.

2.13.7 Physician Incentive Plan (PIP)

2.13.7.1 The CONTRACTOR shall notify and make TENNCARE and TDCI aware of any operations or plans to operate a physician incentive plan (PIP). Prior to implementation of any such plans, the CONTRACTOR shall submit to TDCI any provider agreement templates or subcontracts that involve a PIP for review as a material modification.

2.13.7.2 The CONTRACTOR shall not implement a PIP in the absence of TDCI review and written approval.

2.13.7.3 If the CONTRACTOR operates a PIP, the CONTRACTOR shall ensure that no specific payment be made directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

2.13.7.4 If the CONTRACTOR operates a PIP, upon TENNCARE’s request, the CONTRACTOR shall report descriptive information about its incentive plan in sufficient detail to enable TENNCARE to adequately monitor the CONTRACTOR. The information that may be requested shall include, but not be limited to, the following:

2.13.7.4.1 Whether services not furnished by the physician or physician group are covered by the incentive plan;

2.13.7.4.2 The type or types of incentive arrangements, such as, withholds, bonus, capitation;

2.13.7.4.3 The percent of any withhold or bonus the plan uses;

2.13.7.4.4 Assurance that the physicians or physician group has adequate stop-loss protection, and the amount and type of stop-loss protection; and

2.13.7.4.5 The patient panel size and, if the plan uses pooling, the pooling method.

2.13.8 Emergency Services Obtained from Non-Contract Providers

2.13.8.1 Payments to non-contract providers for emergency services may, at the CONTRACTOR’s option, be limited to the treatment of emergency medical conditions, including post-stabilization care services, as described in Section 1. Payment amounts shall be consistent with the pricing policies developed by the CONTRACTOR and in accordance with TENNCARE requirements, including TennCare rules and regulations for emergency services provided by non-contract providers.

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- 2.13.8.2 Payment by the CONTRACTOR for properly documented claims for emergency services rendered by a non-contract provider shall be made within thirty (30) calendar days of receipt of a clean claim by the CONTRACTOR.
- 2.13.8.3 The CONTRACTOR shall review and approve or disapprove claims for emergency services based on the definition of emergency services specified in Section 1 of this Agreement. If the CONTRACTOR determines that a claim requesting payment of emergency services does not meet the definition as specified in Section 1 and subsequently denies the claim, the CONTRACTOR shall notify the provider of the denial. This notification shall include information to the provider regarding the CONTRACTOR's process and time frames for reconsideration. In the event a provider disagrees with the CONTRACTOR's decision to disapprove a claim for emergency services, the provider may pursue the independent review process for disputed claims as provided by TCA 56-32-126, including but not limited to reconsideration by the CONTRACTOR.
- 2.13.9 Medically Necessary Services Obtained from Non-Contract Provider when MCO Assignment is Unknown**
- 2.13.9.1 The CONTRACTOR shall pay for medically necessary covered services provided to an enrollee by a non-contract provider when TENNCARE has enrolled the enrollee in the CONTRACTOR's MCO, but the enrollee could not have known which MCO they were enrolled in at the time of the service. Examples of when this may occur include, but are not limited to, (i) when an enrollee receives services during a retroactive eligibility period (see Section 2.4.5) and the enrollee did not select an MCO and is assigned to an MCO by TENNCARE, or (ii) the enrollee was assigned to an MCO other than the one that he/she requested. In these cases, the effective date of enrollment may occur prior to the CONTRACTOR or the enrollee being notified of the enrollee becoming a member of the CONTRACTOR's MCO.
- 2.13.9.2 When this situation arises, the CONTRACTOR shall not deny payment for medically necessary covered services provided during this period of eligibility for lack of prior authorization or lack of referral; likewise, the CONTRACTOR shall not deny a claim on the basis of the provider's failure to file a claim within a specified time period after the date of service when the provider could not have reasonably known which MCO the enrollee was in during the timely filing period. However, in such cases the CONTRACTOR may impose timely filing requirements beginning on the date of notification of the individual's enrollment.
- 2.13.10 Medically Necessary Services Obtained from Contract Provider without Prior Authorization when MCO Assignment is Unknown**
- 2.13.10.1 The CONTRACTOR shall pay for medically necessary covered services provided to an enrollee by a contract provider without prior authorization or referral when TENNCARE has enrolled the enrollee in the CONTRACTOR's MCO, but the enrollee could not have known which MCO they were enrolled in at the time of the service.
- 2.13.10.2 When this situation arises, the CONTRACTOR shall not deny payment for medically necessary covered services for lack of prior authorization or lack of referral; likewise, a CONTRACTOR shall not deny a claim on the basis of the provider's failure to file a claim within a specified time period after the date of service when the provider could not have reasonably known which MCO the enrollee was in during the timely filing period. However, in such cases the CONTRACTOR may impose timely filing requirements beginning on the date of notification of the individual's enrollment.
- 2.13.11 Medically Necessary Services Obtained from Non-Contract Provider Referred by Contract Provider**
- The CONTRACTOR shall pay for any medically necessary covered services provided to a member by a non-contract provider at the request of a contract provider. The CONTRACTOR's payment shall not be less than eighty percent (80%) of the rate that would have been paid by the CONTRACTOR if the member had received the services from a contract provider.

2.13.12 Medically Necessary Services Obtained from Non-Contract Provider Not Authorized by the CONTRACTOR

- 2.13.12.1 With the exception of circumstances described in Section 2.13.11, when an enrollee has utilized medically necessary non-emergency covered services from a non-contract provider, and the CONTRACTOR has not authorized such use in advance, the CONTRACTOR shall not be required to pay for the service(s) received unless payment is required pursuant to a directive from TENNCARE or an Administrative Law Judge.
- 2.13.12.2 The CONTRACTOR shall not make payment to non-contract providers for covered services that are not medically necessary.

2.13.13 Covered Services Ordered by Medicare Providers for Dual Eligibles

- 2.13.13.1 Generally, when a TennCare enrollee is dually eligible for Medicare and TennCare and requires services that are covered under this Agreement but are not covered by Medicare, and the services are ordered by a Medicare provider who is a non-contract provider, the CONTRACTOR shall pay for the ordered, medically necessary service if it is provided by a contract provider. However, if all of the following criteria are met, the CONTRACTOR may require that the ordering physician be a contract provider:
 - 2.13.13.1.1 The ordered service requires prior authorization; and
 - 2.13.13.1.2 Dually eligible enrollees have been clearly informed of the contract provider requirement and instructed in how to obtain assistance identifying and making an appointment with a contract provider; and
 - 2.13.13.1.3 The CONTRACTOR assists the enrollee in obtaining a timely appointment with a contract provider upon request of the enrollee or upon receipt of an order from a non-contract provider.
- 2.13.13.2 Reimbursement shall be at the same rate that would have been paid had the service been ordered by a contract provider.
- 2.13.13.3 The CONTRACTOR shall not pay for non-covered services, services that are not medically necessary, or services ordered and obtained from non-contract providers.

2.13.14 Transition of New Members

Pursuant to the requirements in Section 2.9.2.1 regarding transition of new members, the CONTRACTOR shall not deny payment for the costs of continuation of medically necessary covered services provided by contract or non-contract providers for lack of prior authorization or lack of referral during the required time period for continuation of services. However, if, pursuant to Section 2.9.2.1, the CONTRACTOR requires prior authorization for continuation of services beyond thirty (30) calendar days, the CONTRACTOR may deny payment for care rendered beyond the initial thirty (30) days for lack of prior authorization but may not do so solely on the basis that the provider is a non-contract provider.

2.13.15 Transition of Care

In accordance with the requirements in Section 2.9.3.1 of this Agreement, if a provider has terminated participation with the CONTRACTOR, the CONTRACTOR shall pay the non-contract provider for the continuation of treatment through the applicable period provided in Section 2.9.3.1.

2.13.16 Limits on Payments to Providers and Subcontractors Related to the CONTRACTOR

- 2.13.16.1 The CONTRACTOR shall not pay more for similar services rendered by any provider or subcontractor that is related to the CONTRACTOR than the CONTRACTOR pays to providers and subcontractors that are not related to the CONTRACTOR. For purposes of this

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subsection, “related to” means providers or subcontractors that have an indirect ownership interest or ownership or control interest in the CONTRACTOR, an affiliate (see definition in Section 1 of this Agreement) of the CONTRACTOR, or the CONTRACTOR’s management company as well as providers or subcontractors that the CONTRACTOR, an affiliate of the CONTRACTOR or the CONTRACTOR’s management company has an indirect ownership interest or ownership or control interest in. The standards and criteria for determining indirect ownership interest, an ownership interest or a control interest are set out at 42 CFR Part 455, Subpart B.

2.13.16.2 Any payments made by the CONTRACTOR that exceed the limitations set forth in this section shall be considered non-allowable payments for covered services and shall be excluded from medical expenses reported in the Medical Fund Target report required in Section 2.30.14.2.1.

2.13.16.3 As provided in Section 2.30.9 of this Agreement, the CONTRACTOR shall submit information on payments to related providers and subcontractors.

2.13.17 **1099 Preparation**

In accordance with federal requirements, the CONTRACTOR shall prepare and submit Internal Revenue Service (IRS) Form 1099s for all providers who are not employees of the CONTRACTOR to whom payment is made

2.13.18 **Interest**

Interest generated from the deposit of funds for provider payments shall be the property of the State. The amount of interest earned on the funds, as reported by the CONTRACTOR’s bank on the monthly statement, shall be deducted from the amount of the next remittance request subsequent to receipt of the bank statement.

2.13.19 **Immediate Eligibility**

Medical service payments made in accordance with Section 2.13 shall include payments to providers for services provided during a period of Immediate Eligibility. However, in order to facilitate the invoicing of DCS for services provided to children in state custody who are not TennCare eligible, the CONTRACTOR shall submit to TENNCARE an itemized listing of claims paid on behalf children in state custody for whom Immediate Eligibility was established in accordance with this Agreement and who were not subsequently found to be TennCare eligible, on a monthly basis in the form and format specified in Attachment XIII, Exhibit N.

2.14 UTILIZATION MANAGEMENT (UM)

2.14.1 **General**

2.14.1.1 The CONTRACTOR shall develop and maintain a utilization management (UM) program. As part of this program the CONTRACTOR shall have policies and procedures with defined structures and processes. The UM program shall assign responsibility to appropriate individuals including a designated senior physician and shall involve a designated behavioral health care practitioner in the implementation of behavioral health aspects of the program. The UM program shall be supported by an associated work plan and shall be evaluated annually and updated as necessary.

2.14.1.2 The CONTRACTOR shall notify all network providers of and enforce compliance with all provisions relating to UM procedures.

2.14.1.3 The UM program shall have criteria that:

2.14.1.3.1 Are objective and based on medical and/or behavioral health evidence;

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- 2.14.1.3.2 Are applied based on individual needs;
- 2.14.1.3.3 Are applied based on an assessment of the local delivery system;
- 2.14.1.3.4 Involve appropriate practitioners in developing, adopting and reviewing them; and
- 2.14.1.3.5 Are annually reviewed and up-dated as appropriate.
- 2.14.1.4 The CONTRACTOR shall use appropriately licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each level of UM, including prior authorization and decision making. The CONTRACTOR shall have written procedures documenting access to Board Certified Consultants to assist in making medical necessity determinations. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a physical health or behavioral health care professional who has appropriate clinical expertise in treating the member's condition or disease.
- 2.14.1.5 Except as provided in Section 2.6.1.4, the CONTRACTOR shall not place maximum limits on the length of stay for members requiring hospitalization and/or surgery. The CONTRACTOR shall not employ, and shall not permit others acting on their behalf to employ utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each member and his/her medical history. The CONTRACTOR shall consider individual member characteristics in the determination of readiness for discharge. This requirement is not intended to limit the ability of the CONTRACTOR to use clinical guidelines or criteria in placing tentative limits on the length of a prior authorization or pre-admission certification.
- 2.14.1.6 The CONTRACTOR shall have mechanisms in place to ensure that required services are not arbitrarily denied or reduced in amount, duration, or scope solely because of the diagnosis, type of illness, or condition.
- 2.14.1.7 The CONTRACTOR shall assure, consistent with 42 CFR 438.6(h), 42 CFR 422.208 and 422.210, that compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member.
- 2.14.1.8 As part of the provider survey required by Section 2.18.7.3, the CONTRACTOR shall assess provider/office staff satisfaction with UM processes to identify areas for improvement.
- 2.14.1.9 Inpatient Care

The CONTRACTOR shall provide for methods of assuring the appropriateness of inpatient care. Such methodologies shall be based on individualized determinations of medical necessity in accordance with UM policies and procedures and, at a minimum, shall include the items specified in subparagraphs 2.14.1.9.1 through 2.14.1.9.5 below:
- 2.14.1.9.1 Pre-admission certification process for non-emergency admissions;
- 2.14.1.9.2 A concurrent review program to monitor and review continued inpatient hospitalization, length of stay, or diagnostic ancillary services regarding their appropriateness and medical necessity. In addition, the CONTRACTOR shall have a process in place to determine for emergency admissions, based upon medical criteria, if and when a member can be transferred to a contract facility in the network, if presently in a non-contract facility;
- 2.14.1.9.3 Admission review for urgent and/or emergency admissions, on a retroactive basis when necessary, in order to determine if the admission is medically necessary and if the requested length of stay for the admission is reasonable based upon an individualized determination of

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medical necessity. Such reviews shall not result in delays in the provision of medically necessary urgent or emergency care;

2.14.1.9.4 Restrictions against requiring pre-admission certification for admissions for the normal delivery of children; and

2.14.1.9.5 Prospective review of same day surgery procedures.

2.14.1.10 Emergency Department (ED) Utilization

The CONTRACTOR shall utilize the following guidelines in identifying and managing care for members who are determined to have excessive and/or inappropriate ED utilization:

2.14.1.10.1 Review ED utilization data, at a minimum, every six (6) months (in January and July) to identify members with utilization exceeding the threshold defined by TENNCARE in the preceding six (6) month period. The January review shall cover ED utilization during the preceding April through September; the July review shall cover ED utilization during the preceding October through March;

2.14.1.10.2 Enroll members whose utilization exceeds the threshold of ED visits defined by TENNCARE in the previous six (6) month period in MCO case management if appropriate;

2.14.1.10.3 As appropriate, make contact with members whose utilization exceeded the threshold of ED visits defined by TENNCARE in the previous six (6) month period and their primary care providers for the purpose of providing education on appropriate ED utilization; and

2.14.1.10.4 Assess the most likely cause of high utilization and develop an MCO case management plan based on results of the assessment for each member.

2.14.1.11 Hospitalizations and Surgeries

The CONTRACTOR shall comply with any applicable federal and state laws or rules related to length of hospital stay. TENNCARE will closely monitor encounter data related to length of stay and re-admissions to identify potential problems. If indicated, TENNCARE may conduct special studies to assess the appropriateness of hospital discharges.

2.14.2 **Prior Authorization for Covered Services**

2.14.2.1 General

2.14.2.1.1 The CONTRACTOR shall have in place, and follow, written policies and procedures for processing requests for initial and continuing prior authorizations of services and have in effect mechanisms to ensure consistent application of review criteria for prior authorization decisions. The policies and procedures shall provide for consultation with the requesting provider when appropriate. If prior authorization of a service is granted by the CONTRACTOR and the service is provided, payment for the prior authorized service shall not be denied based on the lack of medical necessity, assuming that the member is eligible on the date of service, unless it is determined that the facts at the time of the denial of payment are significantly different than the circumstances which were described at the time that prior authorization was granted.

2.14.2.1.2 Prior authorization requests shall be reviewed subject to the guidelines described in TennCare rules and regulations which include, but are not limited to, provisions regarding decisions, notices, medical contraindication, and the failure of an MCO to act timely upon a request.

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2.14.2.2 Notice of Adverse Action Requirements

2.14.2.2.1 The CONTRACTOR shall clearly document and communicate the reasons for each denial of a prior authorization request in a manner sufficient for the provider and member to understand the denial and decide about requesting reconsideration of or appealing the decision.

2.14.2.2.2 The CONTRACTOR shall comply with all member notice provisions in TennCare rules and regulations.

2.14.2.3 Medical History Information Requirements

2.14.2.3.1 The CONTRACTOR is responsible for eliciting pertinent medical history information from the treating health care provider(s), as needed, for purposes of making medical necessity determinations. The CONTRACTOR shall take action (e.g., sending a CONTRACTOR representative to obtain the information and/or discuss the issue with the provider, imposing financial penalties against the provider, etc.), to address the problem if a treating health care provider is uncooperative in supplying needed information. The CONTRACTOR shall make documentation of such action available to TENNCARE, upon request. Providers who do not provide requested medical information for purposes of making a medical necessity determination for a particular item or service shall not be entitled to payment for the provision of such item or service.

2.14.2.3.2 Upon request by TENNCARE, the CONTRACTOR shall provide TENNCARE with individualized medical record information from the treating health care provider(s). The CONTRACTOR shall take whatever action necessary to fulfill this responsibility within the required appeal time lines as specified by TENNCARE and/or applicable TennCare rules and regulations, up to and including going to the provider's office to obtain the medical record information. Should a provider fail or refuse to respond to the CONTRACTOR's efforts to obtain medical information, and the appeal is decided in favor of the member, at the CONTRACTOR's discretion or a directive by TENNCARE, the CONTRACTOR shall impose financial penalties against the provider as appropriate.

2.14.3 **Referrals**

2.14.3.1 Except as provided in Section 2.14.4, the CONTRACTOR may require members to seek a referral from their PCP prior to accessing non-emergency specialty physical health services.

2.14.3.2 If the CONTRACTOR requires members to obtain PCP referral, the CONTRACTOR may exempt certain services, identified by the CONTRACTOR in the member handbook, from PCP referral.

2.14.3.3 For members determined to need a course of treatment or regular care monitoring, the CONTRACTOR shall have a mechanism in place to allow members to directly access a specialist as appropriate for the members' condition and identified needs.

2.14.3.4 The CONTRACTOR shall not require that a woman go in for an office visit with her PCP in order to obtain the referral for prenatal care.

2.14.3.5 Referral Provider Listing

2.14.3.5.1 The CONTRACTOR shall provide all PCPs with a current hard copy listing of referral providers, including behavioral health providers at least thirty (30) calendar days prior to the start date of operations. Thereafter the CONTRACTOR shall mail PCPs an updated version of the listing on a quarterly basis. The CONTRACTOR shall also maintain an updated electronic, web-accessible version of the referral provider listing.

2.14.3.5.2 The referral provider listing shall be in the format specified by TENNCARE for the provider directory in Section 2.17.7.

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- 2.14.3.5.3 As required in Section 2.30.10.6, the CONTRACTOR shall submit to TENNCARE a copy of the referral provider listing, a data file of the provider information in a media and format described by TENNCARE, and documentation regarding mailing.

2.14.4 Exceptions to Prior Authorization and/or Referrals

2.14.4.1 Emergency and Post-Stabilization Care Services

The CONTRACTOR shall provide emergency services without requiring prior authorization or PCP referral, as described in Section 2.6.11, regardless of whether these services are provided by a contract or non-contract provider. The CONTRACTOR shall provide post-stabilization care services (as defined in Section 1) in accordance with 42 CFR 422.113.

2.14.4.2 TENnderCare

The CONTRACTOR shall not require prior authorization or PCP referral for the provision of TENnderCare screening services.

2.14.4.3 Access to Women's Health Specialists

The CONTRACTOR shall allow female members direct access (without requiring a referral) to a women's health specialist who is a contract provider for covered services necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist.

2.14.4.4 Behavioral Health Services

The CONTRACTOR shall not require a PCP referral for members to access a behavioral health provider.

2.14.4.5 Transition of New Members

Pursuant to the requirements in Section 2.9.2.1 regarding transition of new members, the CONTRACTOR shall provide for the continuation of medically necessary covered services regardless of prior authorization or referral requirements. However, as provided in Section 2.9.2.1, in certain circumstances the CONTRACTOR may require prior authorization for continuation of services beyond the initial thirty (30) days.

2.14.5 PCP Profiling

The CONTRACTOR shall profile its PCPs. Further, the CONTRACTOR shall investigate the circumstances surrounding PCPs who appear to be operating outside peer norms and shall intervene, as appropriate, when utilization or quality of care issues are identified. As part of these profiling activities, the CONTRACTOR shall analyze utilization data, including but not limited to, information provided to the CONTRACTOR by TENNCARE, and report back information as requested by TENNCARE. PCP profiling shall include, but not be limited to the following areas:

2.14.5.1 Utilization of Non-Contract Providers

The CONTRACTOR shall maintain a procedure to identify and evaluate member utilization of services provided by non-contract providers by PCP panel.

2.14.5.2 Specialist Referrals

The CONTRACTOR shall maintain a procedure to identify and evaluate member specialty provider utilization by PCP panel.

2.14.5.3 Emergency Room Utilization

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The CONTRACTOR shall maintain a procedure to identify and evaluate member emergency room utilization by PCP panel. As provided in Section 2.9.4, members who establish a pattern of accessing emergency room services shall be referred to MCO case management as appropriate for follow-up.

2.14.5.4 Inpatient Admissions

The CONTRACTOR shall maintain a procedure to identify and evaluate member utilization of inpatient services by PCP panel.

2.14.5.5 Pharmacy Utilization

At a minimum, the CONTRACTOR shall profile PCP prescribing patterns for generic versus brand name and the number of narcotic prescriptions written. In addition, the CONTRACTOR shall comply with the requirements in Section 2.9.7 of this Agreement.

2.14.5.6 Advanced Imaging Procedures

The CONTRACTOR shall profile the utilization of advanced imaging procedures by PCP panel. Advanced imaging procedures include: PET Scans; CAT Scans and MRIs.

2.14.5.7 PCP Visits

The CONTRACTOR shall profile the average number of visits per member assigned to each PCP.

2.15 QUALITY MANAGEMENT/QUALITY IMPROVEMENT

2.15.1 Quality Management/Quality Improvement (QM/QI) Program

2.15.1.1 The CONTRACTOR shall have a written Quality Management/Quality Improvement (QM/QI) program that clearly defines its quality improvement structures and processes and assigns responsibility to appropriate individuals. This QM/QI program shall use as a guideline the current NCQA Standards and Guidelines for the Accreditation of MCOs and shall include the CONTRACTOR's plan for improving patient safety. This means at a minimum that the QM/QI program shall:

2.15.1.1.1 Specifically address behavioral health care;

2.15.1.1.2 Be accountable to the CONTRACTOR's board of directors and executive management team;

2.15.1.1.3 Have substantial involvement of a designated physician and designated behavioral health practitioner;

2.15.1.1.4 Have a QM/QI committee that oversees the QM/QI functions;

2.15.1.1.5 Have an annual work plan;

2.15.1.1.6 Have resources – staffing, data sources and analytical resources – devoted to it; and

2.15.1.1.7 Be evaluated annually and updated as appropriate.

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- 2.15.1.2 The CONTRACTOR shall make all information about its QM/QI program available to providers and members.
- 2.15.1.3 As part of the QM/QI program, the CONTRACTOR shall collect information on providers' actions to improve patient safety and make performance data available to providers and members.
- 2.15.1.4 Any changes to the QM/QI program structure shall require prior written approval from TENNCARE. The QM/QI program description, associated work plan, and annual evaluation of the QM/QI Program shall be submitted to TENNCARE as required in Section 2.30.11.1, Reporting Requirements.

2.15.2 QM/QI Committee

- 2.15.2.1 The CONTRACTOR shall have a QM/QI committee which shall include staff and contract providers. Medical and behavioral health staff and contract providers shall be represented on the QM/QI committee. This committee shall recommend policy decisions, analyze and evaluate the results of QM/QI activities, ensure that providers are involved in the QM/QI program, institute needed action, and ensure that appropriate follow-up occurs. This committee shall also review and approve the QM/QI program description and associated work plan prior to submission to TENNCARE as required in Section 2.30.11.1, Reporting Requirements.
- 2.15.2.2 The QM/QI committee shall keep written minutes of all meetings. A copy of the signed and dated written minutes for each meeting shall be available on-file after the completion of the following committee meeting in which the minutes are approved and shall be available for review upon request and during the annual on-site EQRO review and/or NCQA accreditation review.
- 2.15.2.3 The CONTRACTOR shall provide the Chief Medical Officer of TENNCARE with ten (10) calendar days advance notice of all regularly scheduled meetings of the QM/QI committee. To the extent allowed by law, the Chief Medical Officer of TENNCARE, or his/her designee, may attend the QM/QI committee meetings at his/her option.

2.15.3 Performance Improvement Projects (PIPs)

- 2.15.3.1 The CONTRACTOR shall perform two (2) clinical and one (1) non-clinical PIP. The two (2) clinical PIPs shall include one (1) in the area of behavioral health. The behavioral health PIP shall be relevant to one of the behavioral health disease management programs for bipolar disorder, major depression, or schizophrenia.
- 2.15.3.2 The CONTRACTOR shall ensure that CMS protocols for PIPs are followed and that the following are documented for each activity:
 - 2.15.3.2.1 Rationale for selection as a quality improvement activity;
 - 2.15.3.2.2 Specific population targeted, include sampling methodology if relevant;
 - 2.15.3.2.3 Metrics to determine meaningful improvement and baseline measurement;
 - 2.15.3.2.4 Specific interventions (enrollee and provider);
 - 2.15.3.2.5 Relevant clinical practice guidelines; and
 - 2.15.3.2.6 Date of re-measurement.
- 2.15.3.3 The CONTRACTOR shall identify benchmarks and set achievable performance goals for each of its PIPs. The CONTRACTOR shall identify and implement intervention and

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improvement strategies for achieving the performance goal set for each PIP and ensuring sustained improvements.

2.15.3.4 The CONTRACTOR shall report on PIPs as required in Section 2.30.11.3, Reporting Requirements.

2.15.3.5 After three (3) years, the CONTRACTOR shall, using evaluation criteria established by TENNCARE, determine if one or all of the current PIPs should be continued. If the CONTRACTOR decides to discontinue a PIP, the CONTRACTOR shall identify a new PIP, which must be prior approved by TENNCARE.

2.15.4 Clinical Practice Guidelines

The CONTRACTOR shall utilize evidence-based clinical practice guidelines in its disease management programs and shall measure performance against at least two (2) important aspects of each of the guidelines annually as required in Section 2.8. The guidelines shall be reviewed and revised at least every two (2) years or whenever the guidelines change.

2.15.5 NCQA Accreditation

2.15.5.1 The CONTRACTOR shall maintain NCQA accreditation throughout the period of this Agreement.

2.15.5.2 Following accreditation or re-accreditation, the CONTRACTOR must submit a copy of the bound report from NCQA” within 10 days of receipt of the report.

2.15.5.3 Failure to maintain NCQA Accreditation shall be considered a breach of this Agreement and shall result in termination of this Agreement in accordance with the terms set forth in Section 5.2 of this Agreement. Achievement of provisional accreditation status shall require a corrective action plan within thirty (30) calendar days of receipt of notification from NCQA and may result in termination of this Agreement in accordance with Section 5.2 of this Agreement.

2.15.6 HEDIS and CAHPS

2.15.6.1 Annually, the CONTRACTOR shall complete all HEDIS measures designated by NCQA as relevant to Medicaid. The only exclusion from the complete Medicaid HEDIS data set shall be dental measures. The CONTRACTOR shall contract with an NCQA certified HEDIS auditor to validate the processes of the CONTRACTOR in accordance with NCQA requirements. Audited HEDIS results shall be submitted to TENNCARE, NCQA and TENNCARE’s EQRO annually by June 15 of each calendar year.

2.15.6.2 Annually, the CONTRACTOR shall conduct a CAHPS survey. The CONTRACTOR shall enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys. The CONTRACTOR’s vendor shall perform the CAHPS adult survey, CAHPS child survey and the CAHPS children with chronic conditions survey. Survey results shall be reported to TENNCARE separately for each required CAHPS survey listed above. Survey results shall be submitted to TENNCARE, NCQA and TENNCARE’s EQRO annually by June 15 of each calendar year.

2.16 MARKETING

2.16.1 The CONTRACTOR shall not conduct any enrollee marketing activities, as defined in Section 1 of this Agreement. This prohibition includes, but is not limited to the following information and activities:

2.16.1.1 Materials and/or activities that mislead, confuse or defraud or that are unfair or deceptive practices or that otherwise violate federal or state consumer protection laws or regulations. This includes materials which mislead or falsely describe covered or available services,

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- membership or availability of network providers, and qualifications and skills of network providers.
- 2.16.1.2 Overly aggressive solicitation, such as repeated telephoning or continued recruitment after an offer for enrollment is declined, or similar techniques;
- 2.16.1.3 Offers of gifts or material or financial gain as incentives to enroll;
- 2.16.1.4 Compensation arrangements with marketing personnel that utilize any type of payment structure in which compensation is tied to the number of persons enrolled;
- 2.16.1.5 Direct solicitation of prospective enrollees;
- 2.16.1.6 Directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities;
- 2.16.1.7 Assertions or statements (whether oral or written) that the enrollee must enroll with the CONTRACTOR in order to obtain benefits or in order not to lose benefits;
- 2.16.1.8 Assertions or statements (whether written or oral) that the CONTRACTOR is endorsed by CMS, the federal or state government or similar entity;
- 2.16.1.9 Use of independent marketing agents in connection with marketing activities. Independent marketing agents shall not mean staff necessary to develop or produce marketing materials or advertising or other similar functions; and
- 2.16.1.10 Seeking to influence enrollment in conjunction with the sale or offering of any private insurance.
- 2.16.2 The prohibition on enrollee marketing shall not apply to health education and outreach activities that are prior approved in writing by TENNCARE. All health education and outreach activities must be prior approved in writing by TENNCARE.
- 2.16.3 The CONTRACTOR shall not use the name of the CONTRACTOR's TennCare MCO in any form of general marketing (as defined in Section 1) without TENNCARE's prior written approval.

2.17 MEMBER MATERIALS

2.17.1 Prior Approval Process for All Member Materials

- 2.17.1.1 The CONTRACTOR shall submit to TENNCARE for review and prior written approval all materials that will be distributed to members (referred to as member materials) as well as proposed health education and outreach activities. This includes but is not limited to member handbooks, provider directories, member newsletters, identification cards, fact sheets, notices, brochures, form letters, mass mailings, member education and outreach activities as described in this Section, and Section 2.17, system generated letters and any other additional, but not required, materials and information provided to members designed to promote health and/or educate members.
- 2.17.1.2 All member materials shall be submitted to TENNCARE on paper and electronic file media, in the format prescribed by TENNCARE. The materials shall be accompanied by a plan that describes the CONTRACTOR's intent and procedure for the use of the materials. Materials developed by a recognized entity having no association with the CONTRACTOR that are related to management of specific types of diseases (e.g., heart, diabetes, asthma, etc.) or general health improvement shall be submitted for approval; however, unless otherwise requested by TENNCARE, an electronic file for these materials is not required. The electronic files shall be submitted in a format acceptable to TENNCARE. Electronic files submitted in any other format than those approved by TENNCARE will not be processed.

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- 2.17.1.3 TENNCARE shall review the submitted member materials and either approve or deny them within fifteen (15) calendar days from the date of submission. In the event TENNCARE does not approve the materials TENNCARE may provide written comments, and the CONTRACTOR shall resubmit the materials.
- 2.17.1.4 Once member materials have been approved in writing by TENNCARE, the CONTRACTOR shall submit to TENNCARE an electronic version of the final printed product and five (5) original prints of the final product, unless otherwise specified by TENNCARE, within thirty (30) calendar days from the print date. Photo copies may not be submitted as a final product. Upon request, the CONTRACTOR shall provide additional original prints of the final product to TENNCARE.
- 2.17.1.5 Prior to modifying any approved member material, the CONTRACTOR shall submit for written approval by TENNCARE a detailed description of the proposed modification. Proposed modifications shall be submitted in accordance with the requirements herein.
- 2.17.1.6 TENNCARE reserves the right to notify the CONTRACTOR to discontinue or modify member materials after approval.

2.17.2 **Written Material Guidelines**

The CONTRACTOR shall comply with the following requirements as it relates to written member materials:

- 2.17.2.1 All member materials shall be worded at a sixth (6th) grade reading level, unless TENNCARE approves otherwise;
- 2.17.2.2 All written materials shall be clearly legible with a minimum font size of 12pt. with the exception of member I.D. cards, and unless otherwise approved in writing by TENNCARE;
- 2.17.2.3 All written materials shall be printed with the assurance of non-discrimination as provided in Section 5.21;
- 2.17.2.4 The following shall not be used on any written materials, including but not limited to member materials, without the written approval of TENNCARE:
 - 2.17.2.4.1 The Seal of the State of Tennessee;
 - 2.17.2.4.2 The TennCare name unless the initials “SM” denoting a service mark, is superscripted to the right of the name (TennCaresm);
 - 2.17.2.4.3 The word “free” unless the service is at no cost to all members. If members have cost sharing responsibilities, the service is not free. Any conditions of payments shall be clearly and conspicuously disclosed in close proximity to the “free” good or service offer; and
 - 2.17.2.4.4 The use of phrases to encourage enrollment such as “keep your doctor” implying that enrollees can keep all of their physicians. Enrollees in TennCare shall not be led to think that they can continue to go to their current physician, unless that particular physician is a contract provider with the CONTRACTOR’s MCO;
- 2.17.2.5 All vital CONTRACTOR documents shall be translated and available in Spanish. Within ninety (90) calendar days of notification from TENNCARE, all vital CONTRACTOR documents shall be translated and available to each Limited English Proficiency group identified by TENNCARE that constitutes five percent (5%) of the TennCare population or one-thousand (1,000) enrollees, whichever is less;
- 2.17.2.6 All written member materials shall notify enrollees that oral interpretation is available for any language at no expense to them and how to access those services;

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- 2.17.2.7 All written member materials shall be made available in alternative formats for persons with special needs at no expense to the member; and
- 2.17.2.8 The CONTRACTOR shall provide written notice to members of any changes in policies or procedures described in written materials previously sent to members. The CONTRACTOR shall provide written notice at least thirty (30) days before the effective date of the change.

2.17.3 Distribution of Member Materials

- 2.17.3.1 The CONTRACTOR shall distribute member materials as required by this Agreement. Required materials, described below, include member handbooks, provider directories, quarterly member newsletters, and identification cards.
- 2.17.3.2 The CONTRACTOR may distribute additional materials and information, other than those required by this Section, Section 2.17, to members in order to promote health and/or educate enrollees.

2.17.4 Member Handbooks

- 2.17.4.1 The CONTRACTOR shall develop a member handbook based on a template provided by TENNCARE, and update it periodically (at least annually). Upon notice to TENNCARE of material changes to the member handbook, the CONTRACTOR shall make appropriate revisions and immediately distribute the revised handbook to members and providers.
- 2.17.4.2 The CONTRACTOR shall distribute member handbooks to members within thirty (30) calendar days of receipt of notice of enrollment in the CONTRACTOR's MCO or prior to enrollees' enrollment effective date as described in Section 2.4.5 and at least annually thereafter. In the event of material revisions to the member handbook, the CONTRACTOR shall distribute the new and revised handbook to all members immediately.
- 2.17.4.3 In situations where there is more than one member in a TennCare case, it shall be acceptable for the CONTRACTOR to mail one (1) member handbook to each address listed for the member's TennCare case number when there is more than one (1) new enrollee assigned to the same case number at the time of enrollment and when subsequent new or updated member handbooks are mailed to members. Should a single individual be enrolled and be added into an existing case, a member handbook (new or updated) shall be mailed to that individual regardless of whether or not a member handbook has been previously mailed to members in the existing case.
- 2.17.4.4 The CONTRACTOR shall distribute a member handbook to all contract providers upon initial credentialing, annually thereafter as handbooks are updated, and whenever there are material revisions. For purposes of providing member handbooks to providers, it shall be acceptable to provide handbooks in electronic format, including but not limited to CD or access via a web link.
- 2.17.4.5 Each member handbook shall, at a minimum, be in accordance with the following guidelines:
 - 2.17.4.5.1 Shall be in accordance with all applicable requirements as described in Section 2.17.2 of this Agreement;
 - 2.17.4.5.2 Shall include a table of contents;
 - 2.17.4.5.3 Shall include an explanation on how members will be notified of member specific information such as effective date of enrollment;
 - 2.17.4.5.4 Shall include a description of services provided including benefit limits, exclusions, and use of non-contract providers;
 - 2.17.4.5.5 Shall include descriptions of both the Medicaid Benefits and the Standard Benefits;

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- 2.17.4.5.6 Shall include a description of TennCare cost sharing responsibilities including an explanation that providers and/or the CONTRACTOR may utilize whatever legal actions are available to collect these amounts. Further, the information shall indicate that the member may not be billed for covered services except for the amounts of the specified TennCare cost sharing responsibilities and of their right to appeal in the event that they are billed for amounts other than their TennCare cost sharing responsibilities;
- 2.17.4.5.7 Shall include information about preventive services for adults and children, including TENNderCare, a listing of covered preventive services, and notice that preventive services are at no cost and without cost sharing responsibilities;
- 2.17.4.5.8 Shall include procedures for obtaining required services, including procedures for obtaining referrals to specialists as well as procedures for obtaining referrals to non-contract providers. The handbook shall advise members that if they need a service that is not available from a contract provider, they will be referred to a non-contract provider and any copayment requirements would be the same as if this provider were a contract provider;
- 2.17.4.5.9 Shall include an explanation of emergency services and procedures on how to obtain emergency services both in and out of the CONTRACTOR's service area, including but not limited to: an explanation of post-stabilization services, the use of 911, locations of emergency settings and locations for post-stabilization services;
- 2.17.4.5.10 Shall include information on how to access the primary care provider on a twenty-four (24) hour basis as well as the twenty-four (24) hour nurse line. The handbook may encourage members to contact the PCP or twenty-four (24) hour nurse line when they have questions as to whether they should go to the emergency room;
- 2.17.4.5.11 Shall include notice of the right to file a complaint as is provided for by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) and a complaint form on which to do so;
- 2.17.4.5.12 Shall include appeal procedures as described in Section 2.19 of this Agreement;
- 2.17.4.5.13 Shall include notice that in addition to the member's right to file an appeal directly to TENNCARE for actions taken by the CONTRACTOR, the member shall have the right to request reassessment of eligibility related decisions directly to TENNCARE;
- 2.17.4.5.14 Shall include written policies on member rights and responsibilities, pursuant to 42 CFR 438.100 and NCQA's Standards and Guidelines for the Accreditation of MCOs;
- 2.17.4.5.15 Shall include written information concerning advance directives as described in 42 CFR 489 Subpart I and in accordance with 42 CFR 422.128;
- 2.17.4.5.16 Shall include notice that enrollment in the CONTRACTOR's MCO invalidates any prior authorization for services granted by another MCO but not utilized by the member prior to the member's enrollment into the CONTRACTOR's MCO and notice of continuation of care when entering the CONTRACTOR's MCO as described in Section 2.9.2 of this Agreement;
- 2.17.4.5.17 Shall include notice to the member that it is the member's responsibility to notify the CONTRACTOR and the TENNCARE agency each and every time the member moves to a new address;
- 2.17.4.5.18 Shall include notice that a new member may request to change MCOs at anytime during the forty-five (45) calendar day period immediately following their initial enrollment in an MCO, subject to the capacity of the selected MCO to accept additional members and any restrictions limiting enrollment levels established by TENNCARE. This notice shall include instructions on how to contact TENNCARE to request a change;

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- 2.17.4.5.19 Shall include notice that the member may change MCOs at the next choice period as described in Section 2.4.7.2.2 of this Agreement and shall have a forty-five (45) calendar day period immediately following the enrollment, as requested during said choice period, in a new MCO to request to change MCOs, subject to the capacity of the selected MCO to accept additional enrollees and any restrictions limiting enrollment levels established by TENNCARE. This notice shall include instructions on how to contact TENNCARE to request a change;
- 2.17.4.5.20 Shall include notice that the member has the right to appeal to TENNCARE to request to change MCOs based on hardship and how to do so;
- 2.17.4.5.21 Shall include notice of the enrollee's right to terminate participation in the TennCare program at any time with instructions to contact TENNCARE for termination forms and additional information on termination;
- 2.17.4.5.22 Shall include TENNCARE and MCO member services toll-free telephone numbers, including the TENNCARE hotline, the CONTRACTOR's member services information line, and the CONTRACTOR's 24/7 nurse triage/advice line with a statement that the member may contact the CONTRACTOR or TENNCARE regarding questions about the TennCare program as well as the service/information that may be obtained from each line;
- 2.17.4.5.23 Shall include information on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free;
- 2.17.4.5.24 Shall include information educating members of their rights and necessary steps to amend their data in accordance with HIPAA regulations and state law;
- 2.17.4.5.25 Shall include directions on how to request and obtain information regarding the "structure and operation of the MCO" and "physician incentive plans" (see Section 2.13.7);
- 2.17.4.5.26 Shall include information that the member has the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;
- 2.17.4.5.27 Shall include information that the member has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
- 2.17.4.5.28 Shall include information on appropriate prescription drug usage (see Section 2.9.7); and
- 2.17.4.5.29 Shall include any additional information required in accordance with NCQA's Standards and Guidelines for the Accreditation of MCOs.

2.17.5 **Quarterly Member Newsletter**

- 2.17.5.1 General Newsletter. The CONTRACTOR shall, at a minimum, distribute on a quarterly basis a newsletter to all members which is intended to educate the enrollee to the managed care system, proper utilization of services, etc., and encourage utilization of preventive care services.
- 2.17.5.2 Teen/Adolescent Newsletter. The CONTRACTOR shall, at a minimum, distribute on a quarterly basis a newsletter to all enrollees between the ages of 15 and 20 which is intended to educate the enrollee to the managed care system, proper utilization of services, etc., with an emphasis on the encouragement to utilize TENNderCare services.
- 2.17.5.2.1 The Teen/Adolescent Newsletter shall be a product of the MCO Adolescent Well-Care Collaborative. The MCOs will agree on five required topics to include in each newsletter.

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MCOs may include additional articles at their discretion; no deviation from the five agreed upon articles will be allowed unless approved in writing by TENNCARE.

- 2.17.5.2.1.1 The CONTRACTOR shall include the following information in each newsletter:
 - 2.17.5.2.1.1.1 Five teen/adolescent specific articles as agreed upon by the MCO Adolescent Well Care Collaborative; and
 - 2.17.5.2.1.1.2 The procedure on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free; and
 - 2.17.5.2.1.1.3 TENNderCare information, including but not limited to, encouragement to obtain screenings and other preventive care services.
- 2.17.5.3 The CONTRACTOR shall include the following information in each newsletter:
 - 2.17.5.3.1 Specific articles or other specific information as described when requested by TENNCARE. Such requests by TENNCARE shall be limited to two hundred (200) words and shall be reasonable including sufficient notification of information to be included;
 - 2.17.5.3.2 The procedure on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free;
 - 2.17.5.3.3 A notice to members of the right to file a complaint, as is provided for by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), and a CONTRACTOR phone number for doing so. The notice shall be in English and Spanish;
 - 2.17.5.3.4 TENNderCare information, including but not limited to, encouragement to obtain screenings and other preventive care services;
 - 2.17.5.3.5 Information about appropriate prescription drug usage;
 - 2.17.5.3.6 TENNCARE and MCO member services toll-free telephone numbers, including the TENNCARE hotline, the CONTRACTOR's member services information line, and the CONTRACTOR's 24/7 nurse triage/advice line as well as the service/information that may be obtained from each line; and
 - 2.17.5.3.7 The following statement: "To report fraud or abuse to the Office of Inspector General (OIG) you can call toll-free 1-800-433-3982 or go online to www.state.tn.us/tenncare and click on 'Report Fraud'. To report provider fraud or patient abuse to the Medicaid Fraud Control Unit (MFCU), call toll-free 1-800-433-5454."
- 2.17.5.4 The quarterly member newsletters shall be disseminated within thirty (30) calendar days of the start of each calendar year quarter. In order to satisfy the requirement to distribute the quarterly newsletter to all members, it shall be acceptable to mail one (1) quarterly newsletter to each address associated with the member's TennCare case number. In addition to the prior authorization requirement regarding dissemination of materials to members, the CONTRACTOR shall also submit to TENNCARE, five (5) final printed originals, unless otherwise specified by TENNCARE, of the newsletters and documentation from the MCO's mail room or outside vendor indicating the quantity and date mailed to TennCare as proof of compliance by the 30th of the month following each quarter in accordance with the reporting schedules as described in this Agreement.

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2.17.6 Identification Card

Each member shall be provided an identification card, which identifies the member as a participant in the TennCare program within thirty (30) calendar days of notification of enrollment into the CONTRACTOR's MCO or prior to the member's enrollment effective date. The identification card shall be durable (e.g., plastic or other durable paper stock but not regular paper stock), shall comply with all state and federal requirements and, at a minimum, shall include:

- 2.17.6.1 The CONTRACTOR's name and issuer identifier, with the company logo;
- 2.17.6.2 Phone numbers for information and/or authorizations, including for behavioral health services;
- 2.17.6.3 Descriptions of procedures to be followed for emergency or special services;
- 2.17.6.4 The member's identification number;
- 2.17.6.5 The member's name (First, Last and Middle Initial);
- 2.17.6.6 The member's date of birth;
- 2.17.6.7 The member's enrollment effective date;
- 2.17.6.8 Copayment information;
- 2.17.6.9 The Health Insurance Portability and Accountability Act (HIPAA) adopted identifier; and
- 2.17.6.10 The words "Medicaid" or "Standard" based on eligibility.

2.17.7 Provider Directory

- 2.17.7.1 The CONTRACTOR shall distribute provider directories to new members within thirty (30) calendar days of receipt of notification of enrollment in the CONTRACTOR's MCO or prior to the member's enrollment effective date. The CONTRACTOR shall also be responsible for redistribution of updated provider information on a regular basis and shall redistribute a complete and updated provider directory at least on an annual basis. In situations where there is more than one enrollee in a TennCare case, it shall be acceptable for the CONTRACTOR to mail one (1) provider directory to each address listed for the enrollee's TennCare case number when there is more than one (1) new enrollee assigned to the same case number at the time of enrollment and when subsequent updated provider directories are mailed to enrollees. Should a single individual be enrolled and be added into an existing case, a provider directory shall be mailed to that individual regardless of whether or not a provider directory has been previously mailed to enrollees in the existing case.
- 2.17.7.2 Provider directories, and any revisions thereto, shall be submitted to TENNCARE for written approval prior to distribution to enrollees in accordance with Section 2.17.1 of this Agreement. The text of the directory shall be in the format prescribed by TENNCARE. In addition, the provider information used to populate the provider directory shall be submitted as a TXT file or such format as otherwise approved in writing by TENNCARE and be produced using the same extract process as the actual provider directory.
- 2.17.7.3 Provider directories shall include the following: names, locations, telephone numbers, office hours, non-English languages spoken by current network PCPs and specialists, hospital listings including locations of emergency settings and post-stabilization services, identification of providers accepting new patients and whether or not a provider performs TENNderCare screens.

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2.17.8 **Additional Information Available Upon Request**

The CONTRACTOR shall provide all other information to members as required by CMS, including but not limited to the following information to any enrollee who requests it:

- 2.17.8.1 Information regarding the structure and operation of the CONTRACTOR's MCO; and
- 2.17.8.2 Information regarding physician incentive plans, including but not limited to:
 - 2.17.8.2.1 Whether the CONTRACTOR uses a physician incentive plan that affects the use of referral services;
 - 2.17.8.2.2 The type of incentive arrangement; and
 - 2.17.8.2.3 Whether stop-loss protection is provided.

2.18 **CUSTOMER SERVICE**

2.18.1 **Member Services Toll-Free Phone Line**

- 2.18.1.1 The CONTRACTOR shall operate a toll-free telephone line (member services information line) to respond to member questions, comments, and inquiries from the member, the member's family, or the member's provider.
- 2.18.1.2 The CONTRACTOR shall develop member services information line policies and procedures that address staffing, training, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards.
- 2.18.1.3 The member services information line shall handle calls from callers with Limited English Proficiency as well as calls from members who are hearing impaired.
- 2.18.1.4 The CONTRACTOR shall ensure that the member services information line is staffed adequately to respond to members' questions, at a minimum, from 8 a.m. to 5 p.m., in the time zone applicable to the Grand Region being served (for the Middle Grand Region, the applicable time zone shall be Central Time), Monday through Friday, except State of Tennessee holidays.
- 2.18.1.5 The member services information line shall be staffed twenty-four (24) hours a day, seven (7) days a week with qualified nurses to triage urgent care and emergency calls from members. The CONTRACTOR may meet this requirement by having a separate nurse triage/nurse advice line that otherwise meets all of the requirements of this Section, Section 2.18.1.
- 2.18.1.6 The member services information line shall be adequately staffed with staff trained to accurately respond to member questions regarding the TennCare program and the CONTRACTOR's MCO, including but not limited to, covered services, TENNderCare, and the CONTRACTOR's provider network.
- 2.18.1.7 The CONTRACTOR shall measure and monitor the accuracy of responses and phone etiquette and take corrective action as necessary to ensure the accuracy of responses and appropriate phone etiquette by staff.
- 2.18.1.8 The CONTRACTOR shall have an automated system available during non-business hours, including weekends and holidays. This automated system shall provide callers with operating instructions on what to do in case of an emergency and shall include, at a minimum, a voice mailbox for callers to leave messages. The CONTRACTOR shall ensure that the voice mailbox has adequate capacity to receive all messages. The CONTRACTOR shall return messages on the next business day.

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2.18.1.9 Performance Standards for Member Services Line/Queue

2.18.1.9.1 The CONTRACTOR shall adequately staff the member services information line to ensure that the line, including the nurse triage/nurse advice line or queue, meets the following performance standards: less than five percent (5%) call abandonment rate; eighty-five percent (85%) of calls are answered by a live voice within thirty (30) seconds (or the prevailing benchmark established by NCQA); and average wait time for assistance does not exceed ten (10) minutes.

2.18.1.9.2 The CONTRACTOR shall submit the reports required in Section 2.30.12.1 of this Agreement.

2.18.2 **Interpreter and Translation Services**

2.18.2.1 The CONTRACTOR shall develop written policies and procedures for the provision of language interpreter and translation services to any member who needs such services, including but not limited to, members with Limited English Proficiency and members who are hearing impaired.

2.18.2.2 The CONTRACTOR shall provide interpreter and translation services free of charge to members.

2.18.2.3 Interpreter services should be available in the form of in-person interpreters, sign language or access to telephonic assistance, such as the ATT universal line.

2.18.3 **Cultural Competency**

As required by 42 CFR 438.206, the CONTRACTOR shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with Limited English Proficiency and diverse cultural and ethnic backgrounds.

2.18.4 **Provider Services and Toll-Free Telephone Line**

2.18.4.1 The CONTRACTOR shall establish and maintain a provider services function to timely and adequately respond to provider questions, comments, and inquiries.

2.18.4.2 The CONTRACTOR shall operate a toll-free telephone line (provider service line) to respond to provider questions, comments, and inquiries.

2.18.4.3 The CONTRACTOR shall develop provider service line policies and procedures that address staffing, training, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards.

2.18.4.4 The CONTRACTOR shall ensure that the provider service line is staffed adequately to respond to providers' questions at a minimum from 8 a.m. to 5 p.m., in the time zone applicable to the Grand Region being served (for the Middle Grand Region, the applicable time zone shall be Central Time), Monday through Friday, except State of Tennessee holidays.

2.18.4.5 The provider service line shall also be adequately staffed to provide appropriate and timely responses regarding prior authorization requests as described in Section 2.14.2 of this Agreement. The CONTRACTOR may meet this requirement by having a separate utilization management line.

2.18.4.6 The provider service line shall be adequately staffed with staff trained to accurately respond to questions regarding the TennCare program and the CONTRACTOR's MCO, including but not limited to, covered services, TENNderCare, prior authorization and referral requirements, and the CONTRACTOR's provider network.

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- 2.18.4.7 For hospitals that have elected to refer patients with non-urgent/emergent conditions to alternative settings for treatment, the CONTRACTOR shall have a specific process in place whereby the Emergency Department (ED) can contact the CONTRACTOR twenty-four (24) hours a day, seven (7) days a week (24/7) via a toll free phone line to obtain assistance for members with non-urgent/emergent conditions who do not require inpatient admission and who are requesting assistance in scheduling an appointment in an alternate treatment setting. The CONTRACTOR may use the 24/7 nurse triage line described in Section 2.18.1.5 of this Agreement for this purpose or may use another line the CONTRACTOR designates. The CONTRACTOR shall submit a description of how it will meet the requirements regarding its 24/7 ED assistance line, which shall provide the telephone number that will be used for hospitals requiring scheduling assistance and describe the process the CONTRACTOR will use to assure all requests are responded to appropriately, including a description of the training provided to staff answering the 24/7 scheduling assistance line. The CONTRACTOR shall track and report the total number of calls received pertaining to patients in ED's needing assistance in accessing care in an alternative setting in accordance with Section 2.30.12.1.3.
- 2.18.4.8 The CONTRACTOR shall measure and monitor the accuracy of responses and phone etiquette and take corrective action as necessary to ensure the accuracy of responses and appropriate phone etiquette by staff.
- 2.18.4.9 The CONTRACTOR shall have an automated system available during non-business hours. This automated system shall include, at a minimum, a voice mailbox for callers to leave messages. The CONTRACTOR shall ensure that the voice mailbox has adequate capacity to receive all messages. The CONTRACTOR shall return messages on the next business day.
- 2.18.4.10 Performance Standards for UM Line/Queue
- 2.18.4.10.1 The CONTRACTOR shall adequately staff the provider service line to ensure that the utilization management line/queue meets the following performance standards: less than five percent (5%) call abandonment rate; eighty-five percent (85%) of calls are answered by a live voice within thirty (30) seconds (or the prevailing benchmark established by NCQA); and average wait time for assistance does not exceed ten (10) minutes.
- 2.18.4.10.2 The CONTRACTOR shall submit the reports required in Section 2.30.12.1 of this Agreement.
- 2.18.5 Provider Handbook**
- 2.18.5.1 The CONTRACTOR shall issue a provider handbook to all contract providers. The CONTRACTOR may distribute the provider handbook electronically (e.g., via its website) as long as providers are notified about how to obtain the electronic copy and how to request a hard copy at no charge to the provider. At a minimum the provider handbook shall include the following information:
- 2.18.5.1.1 Description of the TennCare program;
- 2.18.5.1.2 Covered services;
- 2.18.5.1.3 Emergency service responsibilities;
- 2.18.5.1.4 TENNderCare services and standards;
- 2.18.5.1.5 Information on members' appeal rights;
- 2.18.5.1.6 Policies and procedures of the provider complaint system;
- 2.18.5.1.7 Medical necessity standards and clinical practice guidelines;
- 2.18.5.1.8 PCP responsibilities;

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- 2.18.5.1.9 Coordination with other TennCare contractors or MCO subcontractors;
- 2.18.5.1.10 Prior authorization, referral and other utilization management requirements and procedures;
- 2.18.5.1.11 Protocol for encounter data element reporting/records;
- 2.18.5.1.12 Medical records standard;
- 2.18.5.1.13 Claims submission protocols and standards, including instructions and all information necessary for a clean claim;
- 2.18.5.1.14 Payment policies;
- 2.18.5.1.15 Member rights and responsibilities;
- 2.18.5.1.16 Important phone numbers of all departments/staff a contract provider may need to reach at the CONTRACTOR's MCO; and
- 2.18.5.1.17 How to reach the provider's assigned provider relations representative.
- 2.18.5.2 The CONTRACTOR shall disseminate bulletins as needed to incorporate any needed changes to the provider handbook.

2.18.6 **Provider Education and Training**

- 2.18.6.1 The CONTRACTOR shall develop an education and training plan and materials for contract providers and provide education and training to contract providers and their staff regarding key requirements of this Agreement.
- 2.18.6.2 The CONTRACTOR shall conduct initial education and training to contract providers at least thirty (30) calendar days prior to the start date of operations.
- 2.18.6.3 The CONTRACTOR shall also conduct ongoing provider education and training as deemed necessary by the CONTRACTOR or TENNCARE in order to ensure compliance with this Agreement.
- 2.18.6.4 The CONTRACTOR shall distribute on a quarterly basis a newsletter to contract providers to update providers on CONTRACTOR initiatives and communicate pertinent information to contract providers.
- 2.18.6.5 The CONTRACTOR's provider relations staff shall contact all contract providers on a semi-annual basis to update contract providers on CONTRACTOR initiatives and communicate pertinent information to contract providers. At least one of the two semi-annual contacts made in a year shall be face-to-face with the provider. Semi-annual contacts that are not conducted face-to-face shall be conducted via a phone conversation with the provider. The CONTRACTOR shall maintain records that provide evidence of compliance with the requirement in this Section 2.18.6.5, including when and how contact is made for each contract provider.

2.18.7 **Provider Relations**

- 2.18.7.1 The CONTRACTOR shall establish and maintain a formal provider relations function to provide ongoing troubleshooting and education for contract providers.
- 2.18.7.2 The CONTRACTOR shall implement policies to monitor and ensure compliance of providers with the requirements of this Agreement.
- 2.18.7.3 The CONTRACTOR shall conduct an annual survey to assess provider satisfaction, including satisfaction with provider enrollment, provider communication, and provider education,

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provider complaints, claims processing, claims reimbursement and utilization management processes, including medical reviews. The CONTRACTOR shall submit an annual report on the survey to TENNCARE as required in Section 2.30.12.4. The CONTRACTOR shall take action to address opportunities for improvement identified through the survey. The survey shall be structured so that behavioral health provider satisfaction results and physical health provider satisfaction results can be separately stratified.

2.18.8 Provider Complaint System

2.18.8.1 The CONTRACTOR shall establish and maintain a provider complaint system for any provider (contract or non-contract) who is not satisfied with the CONTRACTOR's policies and procedures or a decision made by the CONTRACTOR that does not impact the provision of services to members.

2.18.8.2 The procedures for resolution of any disputes regarding the payment of claims shall comply with TCA 56-32-126(b).

2.18.9 Member Involvement with Behavioral Health Services

2.18.9.1 The CONTRACTOR shall develop policies and procedures with respect to member, parent, or legally appointed representative involvement with behavioral health. These policies and procedures shall include, at a minimum, the following elements:

2.18.9.1.1 The requirement that all behavioral health treatment plans document member involvement. Fulfilling this requirement means that each treatment plan has a member/family member signature or the signature of a legally appointed representative on the treatment plan and upon each subsequent treatment plan review, where appropriate, and a description of how this requirement will be met;

2.18.9.1.2 The requirement that member education materials include statements regarding the member's, parent's, or legally appointed representative's right to involvement in behavioral health treatment decisions, their ability to choose and change service providers, and a description of how this requirement will be met;

2.18.9.1.3 The requirement that provider education include materials regarding the rights of members, parent(s), or legally appointed representatives to be involved in behavioral health treatment decisions and a description of how this requirement will be met; and

2.18.9.1.4 A description of the quality monitoring activities to be used to measure provider compliance with the requirement for member, parent, or legally appointed representative involvement in behavioral health treatment planning.

2.18.9.2 The CONTRACTOR shall provide an education plan for all members with behavioral health issues; education shall occur on a regular basis. At a minimum, educational materials shall include information on medications and their side effects; behavioral health disorders and treatment options; self-help groups, peer support, and other community support services available for members and families.

2.18.9.3 The CONTRACTOR shall require providers to inform children and adolescents for whom residential treatment is being considered and their parent(s) or legally appointed representative, and adults for whom voluntary inpatient treatment is being considered, of all their options for residential and/or inpatient placement, and alternatives to residential and/or inpatient treatment and the benefits, risks and limitations of each in order that they can provide informed consent.

2.18.9.4 The CONTRACTOR shall require providers to inform all members being considered for prescription of psychotropic medications of the benefits, risks, and side effects of the medication, alternate medications, and other forms of treatment.

2.19 COMPLAINTS AND APPEALS

2.19.1 General

- 2.19.1.1 Members shall have the right to file appeals regarding adverse actions taken by the CONTRACTOR. For purposes of this requirement, appeal shall mean a member's right to contest verbally or in writing, any adverse action taken by the CONTRACTOR to deny, reduce, terminate, delay or suspend a covered service as well as any other acts or omissions of the CONTRACTOR which impair the quality, timeliness, or availability of such benefits. An appeal may be filed by the member or by a person authorized by the member to do so, including but not limited to, a provider with the member's written consent. Complaint shall mean a member's right to contest any other action taken by the CONTRACTOR or service provider other than those that meet the definition of an adverse action. The CONTRACTOR shall inform members of their complaint and appeal rights in the member handbook in compliance with the requirements in Section 2.17.4. The CONTRACTOR shall have internal complaint and appeal procedures for members in accordance with TennCare rules and regulations, the TennCare waiver, consent decrees, or court orders governing the appeals process.
- 2.19.1.2 The CONTRACTOR shall devote a portion of its regularly scheduled QM/QI committee meetings, as described in Section 2.15.2, to the review of member complaints and appeals that have been received.
- 2.19.1.3 The CONTRACTOR shall ensure that punitive action is not taken against a provider who files an appeal on behalf of a member with the member's written consent, supports a member's appeal, or certifies that a member's appeal is an emergency appeal and requires an expedited resolution in accordance with TennCare policies and procedures.

2.19.2 Appeals

- 2.19.2.1 The CONTRACTOR's appeal process shall, at a minimum, meet the requirements outlined herein.
- 2.19.2.2 The CONTRACTOR shall have a contact person who is knowledgeable of appeal procedures and shall direct all appeals, whether the appeal is verbal or the member chooses to file in writing, to TENNCARE. Should a member choose to appeal in writing, the member shall be instructed to file via mail or fax to the designated TENNCARE P. O. Box or fax number for medical appeals.
- 2.19.2.3 The CONTRACTOR shall have sufficient support staff (clerical and professional) available to process appeals in accordance with TennCare requirements related to the appeal of adverse actions affecting a TennCare member. The CONTRACTOR shall notify TENNCARE of the names of appointed staff members and their phone numbers. Staff shall be knowledgeable about applicable state and federal law, TennCare rules and regulations, and all court orders and consent decrees governing appeal procedures, as they become effective.
- 2.19.2.4 The CONTRACTOR shall educate its staff concerning the importance of the appeals procedure, the rights of the member, and the time frames in which action shall be taken by the CONTRACTOR regarding the handling and disposition of an appeal.
- 2.19.2.5 The CONTRACTOR shall identify the appropriate individual or body within the CONTRACTOR's MCO having decision-making authority as part of the appeal procedure.
- 2.19.2.6 The CONTRACTOR shall have the ability to take telephone appeals and accommodate persons with disabilities during the appeals process. Appeal forms shall be available at each service site and by contacting the CONTRACTOR. However, members shall not be required to use a TENNCARE approved appeal form in order to file an appeal.

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- 2.19.2.7 Upon request, the CONTRACTOR shall provide members a TENNCARE approved appeal form(s).
- 2.19.2.8 The CONTRACTOR shall provide reasonable assistance to all appellants during the appeal process.
- 2.19.2.9 At any point in the appeal process, TENNCARE shall have the authority to remove a member from the CONTRACTOR's MCO when it is determined that such removal is in the best interest of the member and TENNCARE.
- 2.19.2.10 The CONTRACTOR shall require providers to display notices of members' right to appeal adverse actions affecting services in public areas of each facility in accordance with TennCare rules and regulations. The CONTRACTOR shall ensure that providers have correct and adequate supply of public notices.
- 2.19.2.11 Neither the CONTRACTOR nor TENNCARE shall prohibit or discourage any individual from testifying on behalf of a member.
- 2.19.2.12 The CONTRACTOR shall ensure compliance with all notice requirements and notice content requirements specified in applicable state and federal law, TennCare rules and regulations, and all court orders and consent decrees governing notice and appeal procedures, as they become effective.
- 2.19.2.13 TENNCARE may develop additional appeal process guidelines or rules, including requirements as to content and timing of notices to members, which shall be followed by the CONTRACTOR. However, the CONTRACTOR shall not be precluded from challenging any judicial requirements and to the extent judicial requirements that are the basis of such additional guidelines or rules are stayed, reversed or otherwise rendered inapplicable, the CONTRACTOR shall not be required to comply with such guidelines or rules during any period of such inapplicability.
- 2.19.2.14 The CONTRACTOR shall provide general and targeted education to providers regarding expedited appeals (described in TennCare rules and regulations), including when an expedited appeal is appropriate, and procedures for providing written certification thereof.
- 2.19.2.15 The CONTRACTOR shall require providers to provide written certification regarding whether a member's appeal is an emergency upon request by a member prior to filing such appeal, or upon reconsideration of such appeal by the CONTRACTOR when requested by TENNCARE.
- 2.19.2.16 The CONTRACTOR shall provide notice to contract providers regarding provider responsibility in the appeal process, including but not limited to, the provision of medical records and/or documentation as described in Section 2.24.4.
- 2.19.2.17 The CONTRACTOR shall urge providers who feel they cannot order a drug on the TennCare Preferred Drug List (PDL) to seek prior authorization in advance, as well as to take the initiative to seek prior authorization or change or cancel the prescription when contacted by a member or pharmacy regarding denial of a pharmacy service due to system edits (e.g., therapeutic duplication, etc.).
- 2.19.2.18 Member eligibility and eligibility-related grievances and appeals, including termination of eligibility, effective dates of coverage, and the determination of premium and copayment responsibilities shall be directed to the Department of Human Services.

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2.20 FRAUD AND ABUSE

2.20.1 General

- 2.20.1.1 The Tennessee Bureau of Investigation, Medicaid Fraud Control Unit (TBI MFCU) is the state agency responsible for the investigation of provider fraud and abuse in the TennCare program.
- 2.20.1.2 The Office of Inspector General (OIG) has the primary responsibility to investigate TennCare enrollee fraud and abuse.
- 2.20.1.3 The CONTRACTOR shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities. The CONTRACTOR shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the CONTRACTOR in preventing and detecting potential fraud and abuse activities.
- 2.20.1.4 The CONTRACTOR shall comply with all federal and state requirements regarding fraud and abuse, including but not limited to Sections 1128, 1156, and 1902(a)(68) of the Social Security Act.

2.20.2 Reporting and Investigating Suspected Fraud and Abuse

- 2.20.2.1 The CONTRACTOR shall cooperate with all appropriate state and federal agencies, including TBI MFCU and/or OIG, in investigating fraud and abuse. In addition, the CONTRACTOR shall fully comply with the TCA 71-5-2601 and 71-5-2603 in performance of its obligations under this Agreement. The CONTRACTOR shall report all confirmed or suspected fraud and abuse to the appropriate agency as follows:
 - 2.20.2.1.1 Suspected fraud and abuse in the administration of the program shall be reported to TBI MFCU and/or OIG;
 - 2.20.2.1.2 All confirmed or suspected provider fraud and abuse shall immediately be reported to TBI MFCU; and
 - 2.20.2.1.3 All confirmed or suspected enrollee fraud and abuse shall be reported immediately to OIG;
- 2.20.2.2 The CONTRACTOR shall use the Fraud Reporting Forms in Attachment X, or such other form as may be deemed satisfactory by the agency to whom the report is to be made under the terms of this Agreement.
- 2.20.2.3 Pursuant to TCA 71-5-2603(c) the CONTRACTOR shall be subject to a civil penalty, to be imposed by the OIG, for willful failure to report fraud and abuse by recipients, enrollees, applicants, or providers to OIG or TBI MFCU, as appropriate.
- 2.20.2.4 The CONTRACTOR shall promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud and abuse. Unless prior written approval is obtained from the agency to whom the incident was reported, or to another agency designated by the agency that received the report, after reporting fraud or suspected fraud and/or suspected abuse and/or confirmed abuse, the CONTRACTOR shall not take any of the following actions as they specifically relate to TennCare claims:
 - 2.20.2.4.1 Contact the subject of the investigation about any matters related to the investigation;
 - 2.20.2.4.2 Enter into or attempt to negotiate any settlement or agreement regarding the incident; or
 - 2.20.2.4.3 Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

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- 2.20.2.5 The CONTRACTOR shall promptly provide the results of its preliminary investigation to the agency to whom the incident was reported, or to another agency designated by the agency that received the report.
- 2.20.2.6 The CONTRACTOR shall cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation shall include providing, upon request, information, access to records, and access to interview CONTRACTOR employees and consultants, including but not limited to those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation.
- 2.20.2.7 The State shall not transfer its law enforcement functions to the CONTRACTOR.
- 2.20.2.8 The CONTRACTOR and providers, whether contract or non-contract, shall, upon request and as required by this Agreement or state and/or federal law, make available to the TBI MFCU/OIG any and all administrative, financial and medical records relating to the delivery of items or services for which TennCare monies are expended. In addition, the TBI MFCU/OIG shall, as required by this Agreement or state and/or federal law, be allowed access to the place of business and to all TennCare records of any contractor or provider, whether contract or non-contract, during normal business hours, except under special circumstances when after hour admission shall be allowed. Special circumstances shall be determined by the TBI MFCU/OIG.
- 2.20.2.9 The CONTRACTOR shall include in any of its provider agreements a provision requiring, as a condition of receiving any amount of TennCare payment, that the provider comply with this Section, Section 2.20 of this Agreement.
- 2.20.2.10 Except as described in Section 2.11.7.2 of this Agreement, nothing herein shall require the CONTRACTOR to ensure non-contract providers are compliant with TENNCARE contracts or state and/or federal law.

2.20.3 Compliance Plan

- 2.20.3.1 The CONTRACTOR shall have a written fraud and abuse compliance plan. A paper and electronic copy of the plan shall be provided to the TennCare Program Integrity Unit within ninety (90) calendar days of Agreement execution and annually thereafter. TENNCARE shall provide notice of approval, denial, or modification to the CONTRACTOR within thirty (30) calendar days of receipt. The CONTRACTOR shall make any requested updates or modifications available for review to TENNCARE as requested by TENNCARE and/or the TennCare Program Integrity Unit within thirty (30) calendar days of a request.
- 2.20.3.2 The CONTRACTOR's fraud and abuse compliance plan shall:
 - 2.20.3.2.1 Require that the reporting of suspected and/or confirmed fraud and abuse be done as required by this Agreement;
 - 2.20.3.2.2 Ensure that all of its officers, directors, managers and employees know and understand the provisions of the CONTRACTOR's fraud and abuse compliance plan;
 - 2.20.3.2.3 Contain procedures designed to prevent and detect abuse and fraud in the administration and delivery of services under this Agreement; and
 - 2.20.3.2.4 Include a description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse, such as:
 - 2.20.3.2.4.1 Claims edits;
 - 2.20.3.2.4.2 Post-processing review of claims;

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- 2.20.3.2.4.3 Provider profiling and credentialing;
- 2.20.3.2.4.4 Prior authorization;
- 2.20.3.2.4.5 Utilization management;
- 2.20.3.2.4.6 Relevant subcontractor and provider agreement provisions; and
- 2.20.3.2.4.7 Written provider and member material regarding fraud and abuse referrals.
- 2.20.3.2.5 Contain provisions for the confidential reporting of plan violations to the designated person;
- 2.20.3.2.6 Contain provisions for the investigation and follow-up of any suspected or confirmed fraud and abuse, even if already reported, and/or compliance plan reports;
- 2.20.3.2.7 Ensure that the identities of individuals reporting violations of the CONTRACTOR's MCO are protected and that there is no retaliation against such persons;
- 2.20.3.2.8 Contain specific and detailed internal procedures for officers, directors, managers and employees for detecting, reporting, and investigating fraud and abuse compliance plan violations;
- 2.20.3.2.9 Require any confirmed or suspected provider fraud and abuse under state or federal law be reported to TBI MFCU and that enrollee fraud and abuse be reported to the OIG; and
- 2.20.3.2.10 Ensure that no individual who reports MCO violations or suspected fraud and abuse is retaliated against.
- 2.20.3.3 The CONTRACTOR shall comply with the applicable requirements of the Model Compliance Plan for Medicaid MCOs or Medicare+Choice Organizations/Medicare Advantage plans issued by the DHHS OIG.
- 2.20.3.4 The CONTRACTOR shall report fraud and abuse activities as required in Section 2.30.13, Reporting Requirements.

2.21 FINANCIAL MANAGEMENT

The CONTRACTOR shall be responsible for sound financial management of its MCO. The CONTRACTOR shall adhere to the minimum guidelines outlined below.

2.21.1 Administrative Payments

The CONTRACTOR shall accept administrative fee payments, premium tax payments, and incentive payments, if applicable, remitted by TENNCARE in accordance with Section 4.

2.21.2 Savings/Loss

2.21.2.1 The CONTRACTOR shall not be required to share with TENNCARE any financial gains realized under this Agreement.

2.21.2.2 TENNCARE shall not share with the CONTRACTOR any financial losses realized under this Agreement.

2.21.3 Interest

Interest generated from the deposit of funds paid to the CONTRACTOR pursuant to this Agreement shall be the property of the CONTRACTOR and available for use at the CONTRACTOR's discretion.

2.21.4 Third Party Liability Resources

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- 2.21.4.1 The TennCare program shall be the payer of last resort for all covered services in accordance with federal regulations. The CONTRACTOR shall exercise full assignment rights as applicable and shall be responsible for making every reasonable effort to determine the legal liability of third parties to pay for services rendered to enrollees under this Agreement and cost avoid and/or recover any such liability from the third party.
- 2.21.4.1.1 If third party liability (TPL) exists for part or all of the services provided directly by the CONTRACTOR to an enrollee, the CONTRACTOR shall make reasonable efforts to recover from TPL sources the value of services rendered.
- 2.21.4.1.2 If TPL exists for part or all of the services provided to an enrollee by a subcontractor or a provider, and the third party will make payment within a reasonable time, the CONTRACTOR may pay the subcontractor or provider only the amount, if any, by which the subcontractor's or provider's allowable claim exceeds the amount of TPL.
- 2.21.4.1.3 If the probable existence of TPL has been established at the time the claim is filed, the CONTRACTOR may reject the claim and return it to the provider for a determination of the amount of any TPL, unless the claim is for one of these services:
 - 2.21.4.1.3.1 TENNderCare;
 - 2.21.4.1.3.2 Prenatal or preventive pediatric care; or
 - 2.21.4.1.3.3 All claims covered by absent parent maintained insurance under Part D of Title IV of the Social Security Act.
- 2.21.4.1.4 The claims specified in Sections 2.21.4.1.3.1, 2.21.4.1.3.2, and 2.21.4.1.3.3 shall be paid at the time presented for payment by the provider and the CONTRACTOR shall bill the responsible third party.
- 2.21.4.2 The CONTRACTOR shall deny payment on a claim that has been denied by a third party payer when the reason for denial is the provider or enrollee's failure to follow prescribed procedures, including but not limited to, failure to obtain prior authorization, timely filing, etc.
- 2.21.4.3 The CONTRACTOR shall treat funds recovered from third parties as offsets to claims payments. The CONTRACTOR shall report all cost avoidance values to TENNCARE in accordance with federal guidelines and as described in Section 2.21.4 of this Agreement
- 2.21.4.4 The CONTRACTOR shall post all third party payments to claim level detail by enrollee.
- 2.21.4.5 Third party resources shall include subrogation recoveries. The CONTRACTOR shall be required to seek subrogation amounts regardless of the amount believed to be available as required by federal Medicaid guidelines. The amount of any subrogation recoveries collected by the CONTRACTOR outside of the claims processing system shall be the property of the State.
- 2.21.4.6 The CONTRACTOR shall conduct diagnosis and trauma code editing to identify potential subrogation claims. This editing should, at minimum, identify claims with a diagnosis of 900.00 through 999.99 (excluding 994.6) or claims submitted with an accident trauma indicator of 'Y.'
- 2.21.4.7 TennCare cost sharing responsibilities permitted pursuant to Section 2.6.15 of this Agreement shall not be considered TPL.
- 2.21.4.8 The CONTRACTOR shall provide TPL data to any provider having a claim denied by the CONTRACTOR based upon TPL.

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- 2.21.4.9 The CONTRACTOR shall provide to TENNCARE any third party resource information necessary in a format and media described by TENNCARE and shall cooperate in any manner necessary, as requested by TENNCARE, with TENNCARE and/or a cost recovery vendor at such time that TENNCARE acquires said services.
- 2.21.4.10 TENNCARE may require a TennCare contracted TPL vendor to review paid claims that are over ninety (90) calendar days old and pursue TPL (excluding subrogation) for those claims that do not indicate recovery amounts in the CONTRACTOR's reported encounter data.
- 2.21.4.11 If the CONTRACTOR operates or administers any non-Medicaid HMO, health plan or other lines of business, the CONTRACTOR shall assist TENNCARE with the identification of enrollees with access to other insurance.
- 2.21.4.12 The CONTRACTOR shall demonstrate, upon request, to TENNCARE that reasonable effort has been made to seek, collect and/or report third party recoveries. TENNCARE shall have the sole responsibility for determining whether or not reasonable efforts have been demonstrated. Said determination shall take into account reasonable industry standards and practices.

2.21.5 Solvency Requirements

2.21.5.1 Minimum Net Worth

- 2.21.5.1.1 The CONTRACTOR shall establish and maintain the minimum net worth requirements required by TDCI, including but not limited to TCA 56-32-112.
- 2.21.5.1.2 Any and all payments made by TENNCARE, including administrative fee payments, as well as incentive payments (if applicable) to the CONTRACTOR shall be considered "Premium revenue" for the purpose of calculating the minimum net worth required by TCA 56-32-112.
- 2.21.5.1.3 The CONTRACTOR shall demonstrate evidence of its compliance with this provision to TDCI in the financial reports filed with TDCI by the CONTRACTOR.

2.21.5.2 Restricted Deposits

The CONTRACTOR shall achieve and maintain restricted deposits in an amount equal to the net worth requirement specified in Section 2.21.5.1. TDCI shall calculate the amount of restricted deposits based on the CONTRACTOR's TennCare premium revenue only unless this calculation would result in restricted deposits below the statutory requirements set forth in TCA 56-32-112 related to restricted deposits; in which case the required amount would be equal to the statutory requirement as it is calculated by TDCI. This contractual requirement shall in no way be construed as a way to circumvent, waive or modify the statutory requirement.

2.21.5.3 Liquidity Ratio Requirement

In addition to the positive working capital requirement described in TCA 56-32-112, the CONTRACTOR shall maintain a liquidity ratio where admitted assets consisting of cash, cash equivalents, short-term investments and bonds exceed total liabilities as reported on the NAIC financial statements.

- 2.21.5.4 If the CONTRACTOR fails to meet and/or maintain the applicable net worth and/or restricted deposit financial requirements in accordance with Sections 2.21.5.1 through 2.21.5.3, as determined by TDCI, the CONTRACTOR agrees that said failure shall constitute hazardous financial conditions as defined by TCA 56-32-112 and the CONTRACTOR shall be considered to be in breach of the terms of the Agreement.

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2.21.6 **Accounting Requirements**

- 2.21.6.1 The CONTRACTOR shall establish and maintain an accounting system in accordance with generally accepted accounting principles. The accounting system shall maintain records pertaining to the tasks defined in this Agreement and any other costs and expenditures made under the Agreement.
- 2.21.6.2 Specific accounting records and procedures are subject to TENNCARE and federal approval. Accounting procedures, policies, and records shall be completely open to state and federal personnel at any time during the Agreement period and for five (5) years thereafter unless otherwise specified elsewhere in this Agreement.

2.21.7 **Insurance**

- 2.21.7.1 The CONTRACTOR shall obtain adequate worker's compensation and general liability insurance coverage prior to commencing any work in connection with this Agreement. Additionally, TENNCARE may require, at its sole discretion, the CONTRACTOR to obtain adequate professional malpractice liability or other forms of insurance. Any insurance required by TENNCARE shall be in the form and substance acceptable to TENNCARE.
- 2.21.7.2 The CONTRACTOR shall require that any subcontractors or contract providers obtain all similar insurance required of it prior to commencing work.
- 2.21.7.3 The CONTRACTOR shall furnish proof of adequate coverage of insurance by a certificate of insurance submitted to TENNCARE.
- 2.21.7.4 TENNCARE shall be exempt from and in no way liable for any sums of money that may represent a deductible in any insurance policy. The payment of such a deductible shall be the sole responsibility of the CONTRACTOR, subcontractor and/or provider obtaining such insurance. The same holds true of any premiums paid on any insurance policy pursuant to this Agreement.
- 2.21.7.5 Failure to provide proof of adequate coverage within the specified time period may result in this Agreement being terminated.

2.21.8 **Ownership and Financial Disclosure**

The CONTRACTOR shall disclose, to TENNCARE, the Comptroller General of the United States or CMS, full and complete information regarding ownership, financial transactions and persons convicted of criminal activity related to Medicare, Medicaid, or the federal Title XX programs in accordance with federal and state requirements, including Public Chapter 379 of the Acts of 1999. This disclosure shall be made in accordance with the requirements in Section 2.30.14.2. The following information shall be disclosed:

- 2.21.8.1 The name and address of each person with an ownership or control interest in the disclosing entity or in any provider or subcontractor in which the disclosing entity has direct or indirect ownership of five percent (5%) or more and whether any of the persons named pursuant to this requirement is related to another as spouse, parent, child, or sibling. This disclosure shall include the name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest;
- 2.21.8.2 The identity of any provider or subcontractor with whom the CONTRACTOR has had significant business transactions, defined as those totaling more than twenty-five thousand dollars (\$25,000) during the twelve (12) month period ending on the date of the disclosure, and any significant business transactions between the CONTRACTOR, any wholly owned supplier, or between the CONTRACTOR and any provider or subcontractor, during the five (5) year period ending on the date of the disclosure;

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- 2.21.8.3 The identity of any person who has an ownership or control interest in the CONTRACTOR, or is an agent or managing employee of the CONTRACTOR and who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the federal Title XX services program since the inception of those programs;
- 2.21.8.4 Disclosure from officials in legislative and executive branches of government as to possible conflicts of interest;
- 2.21.8.5 If the CONTRACTOR is not a federally qualified HMO, the CONTRACTOR shall disclose certain transactions with parties in interest to TENNCARE. Transactions shall be reported according to the following guidelines:
 - 2.21.8.5.1 The CONTRACTOR shall disclose the following transactions:
 - 2.21.8.5.1.1 Any sale, exchange or lease of any property between the HMO and a party in interest;
 - 2.21.8.5.1.2 Any lending of money or other extension of credit between the HMO and a party in interest; and
 - 2.21.8.5.1.3 Any furnishing for consideration of goods, services (including management services) or facilities between the HMO and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.
 - 2.21.8.5.2 The information which shall be disclosed in the transactions includes:
 - 2.21.8.5.2.1 The name of the party in interest for each transaction;
 - 2.21.8.5.2.2 A description of each transaction and the quantity or units involved;
 - 2.21.8.5.2.3 The accrued dollar value of each transaction during the fiscal year; and
 - 2.21.8.5.2.4 Justification of the reasonableness of each transaction.
 - 2.21.8.5.3 If the Agreement is being renewed or extended, the CONTRACTOR shall disclose information on business transactions which occurred during the prior contract period. If the Agreement is an initial Agreement with TENNCARE, but the CONTRACTOR has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period shall be disclosed. The business transactions which shall be reported are not limited to transactions related to serving the Medicaid/TennCare enrollment. All of the CONTRACTOR's business transactions shall be reported.
 - 2.21.8.5.4 A party in interest is:
 - 2.21.8.5.4.1 Any director, officer, partner, or employee responsible for management or administration of an HMO and HIO; any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of the HMO; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than five percent (5%) of the HMO; or, in the case of an HMO organized as a nonprofit corporation, an incorporator or member of such corporation under applicable state corporation law;
 - 2.21.8.5.4.2 Any organization in which a person described in subsection 1 is director, officer or partner; has directly or indirectly a beneficial interest of more than five percent (5%) of the equity of the HMO; or has a mortgage, deed of trust, note, or other interest valuing more than five percent (5%) of the assets of the HMO;
 - 2.21.8.5.4.3 Any person directly or indirectly controlling, controlled by, or under common control with an HMO; or

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- 2.21.8.5.4.4 Any spouse, child, or parent of an individual described in Sections 2.21.8.5.4.1, 2.21.8.5.4.2, or 2.21.8.5.4.3
- 2.21.8.5.5 TENNCARE and/or the Secretary of Health and Human Services may request information to be in the form of a consolidated financial statement.

2.21.9 Internal Audit Function

The CONTRACTOR shall establish and maintain an internal audit function responsible for providing an independent review and evaluation of the CONTRACTOR's accuracy of financial recordkeeping, the reliability and integrity of information, the adequacy of internal controls, and compliance with applicable laws, policies, procedures, and regulations. The CONTRACTOR's internal audit function shall be responsible for performing audits to ensure the economical and efficient use of resources by all departments to accomplish the objectives and goals for the operations of the department. Further, the CONTRACTOR's internal audit department shall be responsible for performance of the claims payment accuracy tests as described in Section 2.22.6 of this Agreement.

2.21.10 Audit of Business Transactions

- 2.21.10.1 The CONTRACTOR shall cause an audit of its business transactions to be performed by a licensed certified public accountant, including but not limited to the financial transactions made under this Agreement. Such audit shall be performed in accordance with the requirements in Section 2.30.14.3.5 of this Agreement.
- 2.21.10.2 No later than December 1 of each year, the CONTRACTOR shall submit a copy of the full executed agreement to audit accounts to TENNCARE. Such agreement shall include the following language:
 - 2.21.10.2.1 The auditor agrees to retain working papers for no less than five (5) years and that all audit working papers shall, upon request, be made available for review by the Comptroller of the Treasury, the Comptroller's representatives, agents, and legal counsel, or the TennCare Division of the Tennessee Department of Commerce and Insurance, during normal working hours while the audit is in progress and/or subsequent to the completion of the report. Nothing in this Section shall be construed to modify or change the obligations of the CONTRACTOR contained in Section 2.23.2 (Data and Document Management Requirements), 2.23.3 (System and Data Integration Requirements), or 2.23.6 (Security and Access Management Requirements) of this Agreement.
 - 2.21.10.2.2 Any evidence of fraud, such as defalcation, misappropriation, misfeasance, malfeasance, embezzlement, fraud or other illegal acts shall be reported by the auditor, in writing immediately upon discovery, to the Comptroller of the Treasury, State of Tennessee, who shall under all circumstances have the authority, at the discretion of the Comptroller, to directly investigate such matters. If the circumstances disclosed by the audit call for a more detailed investigation by the auditor than necessary under ordinary circumstances, the auditor shall inform the organization's governing body in writing of the need for such additional investigation and the additional compensation required therefor. Upon approval by the Comptroller of the Treasury, an amendment to this contract may be made by the organization's governing body and the auditor for such additional investigation.

2.22 CLAIMS MANAGEMENT

2.22.1 General

To the extent that the CONTRACTOR compensates providers on a fee-for-service or other basis requiring the submission of claims as a condition of payment, the CONTRACTOR shall process, as described herein, the provider's claims for covered benefits provided to members consistent with applicable CONTRACTOR policies and procedures and the terms of this Agreement including but not limited to timely filing, and compliance with all applicable state and federal laws, rules and regulations.

2.22.2 Claims Management System Capabilities

- 2.22.2.1 The CONTRACTOR shall maintain a claims management system that can uniquely identify the provider of the service, date of receipt (the date the CONTRACTOR receives the claim as indicated by a date-stamp), real-time-accurate history of actions taken on each provider claim (i.e., paid, denied, suspended, appealed, etc.), date of payment (the date of the check or other form of payment) and all data elements as required by TENNCARE for encounter data submission (see Section 2.23), and can track service use against hard benefit limits in accordance with a methodology set by TENNCARE.
- 2.22.2.2 The CONTRACTOR shall have in place, an electronic claims management (ECM) capability that accepts and processes claims submitted electronically with the exception of claims that require written documentation to justify payment (e.g., hysterectomy/sterilization consent forms, certification for medical necessity for abortion, necessary operative reports, etc.).
- 2.22.2.3 The ECM capability shall function in accordance with information exchange and data management requirements specified in Section 2.23 of this Agreement.
- 2.22.2.4 As part of this ECM function, the CONTRACTOR shall also provide on-line and phone-based capabilities to obtain claims processing status information.
- 2.22.2.5 The CONTRACTOR shall support an automated clearinghouse (ACH) mechanism that allows providers to request and receive electronic funds transfer (EFT) of claims payments.
- 2.22.2.6 The CONTRACTOR shall not derive financial gain from a provider's use of electronic claims filing functionality and/or services offered by the CONTRACTOR or a third party. However, this provision shall not be construed to imply that providers may not be responsible for payment of applicable transaction fees/charges.

2.22.3 Paper Based Claims Formats

- 2.22.3.1 The CONTRACTOR shall comply at all times with standardized paper billing forms/formats (and all future updates) as follows:

Claim Type	Claim Form
Professional	CMS 1500
Institutional	CMS 1450
Dental	ADA

- 2.22.3.2 The CONTRACTOR shall not revise or modify the standardized forms or format.
- 2.22.3.3 For the forms identified in Section 2.22.3.1, the CONTRACTOR shall adhere to national standards and standardized instructions and definitions that are consistent with industry norms that are developed jointly with TENNCARE. These shall include, but not be limited to, HIPAA-based standards, federally required safeguard requirements including signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR 455.18 and 455.19, as well as TDCI rules for Uniform Claims Process for TennCare in accordance with TCA 71-5-191.
- 2.22.3.4 The CONTRACTOR agrees that at such time that TENNCARE in conjunction with appropriate work groups presents recommendations concerning claims billing and processing that are consistent with industry norms, the CONTRACTOR shall comply with said recommendations within ninety (90) calendar days from notice by TENNCARE.

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2.22.4 Prompt Payment

- 2.22.4.1 The CONTRACTOR shall comply with prompt pay claims processing requirements in accordance with TCA 56-32-126.
- 2.22.4.2 The CONTRACTOR shall ensure that ninety percent (90%) of clean claims for payment for services delivered to a TennCare enrollee are paid within thirty (30) calendar days of the receipt of such claims.
- 2.22.4.3 The CONTRACTOR shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all provider claims for covered services delivered to a TennCare enrollee. The terms “processed and paid” are synonymous with terms “process and pay” of TCA 56-32-126(b)(1)(A) and (B).
- 2.22.4.4 If a claim is partially or totally denied on the basis the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written or electronic notice shall specifically identify all such information and documentation. Resubmission of a claim with further information and/or documentation shall constitute a new claim for purposes of establishing the time frame for claims processing.
- 2.22.4.5 To the extent that the provider agreement requires compensation of a provider on a monthly fixed fee basis or on any other basis that does not require the submission of a claim as a condition to payment, such payment shall be made to the provider by no later than (i) the time period specified in the provider agreement/contract between the provider and the CONTRACTOR or subcontractor, or if a time period is not specified in the contract (ii) the tenth (10th) day of the calendar month if the payment is to be made by a subcontractor, or (iii) if the CONTRACTOR is required to compensate the provider directly, within five (5) calendar days after receipt of the capitated payment and supporting remittance advice information from TENNCARE.
- 2.22.4.6 The CONTRACTOR shall not deny provider claims on the basis of untimely filing in situations regarding coordination of benefits or subrogation, in which case the provider is pursuing payment from a third party or if an enrollee is enrolled in the CONTRACTOR’s MCO with a retroactive eligibility date. In situations of third party benefits, the time frames for filing a claim shall begin on the date that the third party documented resolution of the claim. In situations of enrollment in the CONTRACTOR’s MCO with a retroactive eligibility date, the time frames for filing a claim shall begin on the date that the CONTRACTOR receives notification from TENNCARE of the enrollee’s eligibility/enrollment.
- 2.22.4.7 As it relates to MCO Assignment Unknown (see Sections 2.13.9 and 2.13.10), the CONTRACTOR shall not deny a claim on the basis of the provider’s failure to file a claim within a specified time period after the date of service when the provider could not have reasonably known which MCO the member was in during the timely filing period. However, in such cases the CONTRACTOR may impose timely filing requirements beginning on the date of notification of the individual’s enrollment.

2.22.5 Claims Dispute Management

- 2.22.5.1 The CONTRACTOR shall have an internal claims dispute procedure that will be reviewed and approved in writing by TENNCARE prior to its implementation.
- 2.22.5.2 The CONTRACTOR shall contract with independent reviewers to review disputed claims as provided by TCA 56-32-126.
- 2.22.5.3 The CONTRACTOR shall systematically capture the status and resolution of all claim disputes, as well as all associated documentation.

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2.22.6 Claims Payment Accuracy – Minimum Audit Procedures

- 2.22.6.1 On a monthly basis the CONTRACTOR shall submit claims payment accuracy percentage reports (see Section 2.30.15).
- 2.22.6.2 The report shall be based on an audit conducted by the CONTRACTOR. The audit shall be conducted by an entity or staff independent of claims management. Requirements for the internal audit function are outlined in Section 2.21.9 of this Agreement.
- 2.22.6.3 The audit shall utilize a random sample of all “processed or paid” claims upon initial submission in each month (the terms “processed and paid” are synonymous with terms “process and pay” of TCA 56-32-126(b)(1)(A) and (B)). A minimum sample of one-hundred (100) claims randomly selected from the entire population of electronic and paper claims processed or paid upon initial submission for the month tested is required.
- 2.22.6.4 The minimum attributes to be tested for each claim selected shall include:
 - 2.22.6.4.1 Claim data correctly entered into the claims processing system;
 - 2.22.6.4.2 Claim is associated to the correct provider;
 - 2.22.6.4.3 Service obtained the proper authorization;
 - 2.22.6.4.4 Member eligibility at processing date correctly applied;
 - 2.22.6.4.5 Allowed payment amount agrees with contracted rate;
 - 2.22.6.4.6 Duplicate payment of the same claim has not occurred;
 - 2.22.6.4.7 Denial reason applied appropriately;
 - 2.22.6.4.8 Copayment application considered and applied;
 - 2.22.6.4.9 Effect of modifier codes correctly applied;
 - 2.22.6.4.10 Processing considered if service subject to hard benefit limits considered and applied;
 - 2.22.6.4.11 Other insurance properly considered and applied;
 - 2.22.6.4.12 Application of hard benefit limits; and
 - 2.22.6.4.13 Proper coding including bundling/unbundling.
- 2.22.6.5 For audit and verification purposes, the population of claims should be maintained. Additionally, the results of testing at a minimum should be documented to include:
 - 2.22.6.5.1 Results for each attribute tested for each claim selected;
 - 2.22.6.5.2 Amount of overpayment or underpayment for claims processed or paid in error;
 - 2.22.6.5.3 Explanation of the erroneous processing for each claim processed or paid in error;
 - 2.22.6.5.4 Determination if the error is the result of keying errors or the result of errors in the configuration or table maintenance of the claims processing system; and
 - 2.22.6.5.5 Claims processed or paid in error have been corrected.

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- 2.22.6.6 If the CONTRACTOR subcontracts for the provision of any covered services (see Section 2.26), and the subcontractor is responsible for processing claims (see Section 2.26.10), then the CONTRACTOR shall submit a claims payment accuracy percentage report for the claims processed by the subcontractor. The report shall be based on an audit conducted in compliance with the requirements of this Section 2.22.6.

2.22.7 Claims Processing Methodology Requirements

- 2.22.7.1 The CONTRACTOR shall perform front end system edits, including but not limited to:
 - 2.22.7.1.1 Confirming eligibility on each enrollee as claims are submitted on the basis of the eligibility information provided by the State that applies to the period during which the charges were incurred;
 - 2.22.7.1.2 Third party liability (TPL);
 - 2.22.7.1.3 Medical necessity (e.g., appropriate age/sex for procedure);
 - 2.22.7.1.4 Prior approval: the system shall determine whether a covered service required prior approval and, if so, whether the CONTRACTOR granted such approval;
 - 2.22.7.1.5 Duplicate claims: the system shall in an automated manner flag a claim as being (1) exactly the same as a previously submitted claim or (2) a possible duplicate and either deny or pend the claim as needed;
 - 2.22.7.1.6 Covered service: the system shall verify that a service is a covered service and is eligible for payment;
 - 2.22.7.1.7 Provider validation: the system shall approve for payment only those claims received from providers eligible to render services for which the claim was submitted;
 - 2.22.7.1.8 Quantity of service: the system shall evaluate claims for services provided to members to ensure that any applicable hard benefit limits are applied; and
 - 2.22.7.1.9 Benefit limits: the system shall ensure that hard benefit limit rules set by TENNCARE are factored into the determination of whether a claim should be adjudicated and paid.
- 2.22.7.2 The CONTRACTOR shall perform system edits for valid dates of service: the system shall assure that dates of service are valid dates, e.g., not in the future or outside of a member's TennCare eligibility span.
- 2.22.7.3 The CONTRACTOR shall perform post-payment review on a sample of claims to ensure services provided were medically necessary.
- 2.22.7.4 The CONTRACTOR shall have a staff of qualified, medically trained and appropriately licensed personnel, consistent with NCQA accreditation standards, whose primary duties are to assist in evaluating claims for medical necessity.

2.22.8 Explanation of Benefits (EOBs) and Related Functions

- 2.22.8.1 The CONTRACTOR shall be responsible for generating and mailing EOBs to TennCare enrollees in accordance with guidelines described by TENNCARE.
- 2.22.8.2 The CONTRACTOR shall omit any claims in the EOB file that are associated with sensitive services. The CONTRACTOR, with guidance from TENNCARE, shall develop "sensitive services" logic to be applied to the handling of said claims for EOB purposes.
- 2.22.8.3 At a minimum, EOBs shall be designed to address requirements found in 42 CFR 455.20 and 433.116 as well as requirements associated with a change in TennCare policy and shall

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include: claims for services with hard benefit limits, claims with enrollee cost sharing, denied claims with enrollee responsibility, and a sampling of paid claims (excluding ancillary and anesthesia services).

2.22.8.4 Regarding the paid claims sample referenced in Section 2.22.6.3, the CONTRACTOR shall stratify said sample to ensure that all provider types (or specialties) are represented in the pool of generated EOBs. To the extent that the CONTRACTOR considers a particular specialty (or provider) to warrant closer scrutiny, the CONTRACTOR may over sample the group. The paid claims sample should be a minimum of twenty-five (25) claims per check run with a minimum of 100 claims per month.

2.22.8.5 Based on the EOBs sent to TennCare enrollees, the CONTRACTOR shall track any complaints received from enrollees and resolve the complaints according to its established policies and procedures. The resolution may be enrollee education, provider education, or referral to TBI/OIG. The CONTRACTOR shall use the feedback received to modify or enhance the EOB sampling methodology.

2.22.9 Remittance Advices and Related Functions

2.22.9.1 In concert with its claims payment cycle the CONTRACTOR shall provide an electronic status report indicating the disposition for every adjudicated claim for each claim type submitted by providers seeking payment as well as capitated payments generated and paid by the CONTRACTOR.

2.22.9.2 The status report shall contain appropriate explanatory remarks related to payment or denial of the claim, including but not limited to TPL data.

2.22.9.3 If a claim is partially or totally denied on the basis the provider did not submit any required information or documentation with the claim, then the remittance advice shall specifically identify all such information and documentation.

2.22.9.4 In accordance with 42 CFR 455.18 and 455.19, the following statement shall be included on each remittance advice sent to providers: "I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents, or concealment of a material fact, may be prosecuted under applicable federal and/or state laws."

2.22.10 Processing of Payment Errors

The CONTRACTOR shall not employ off-system or gross adjustments when processing corrections to payment errors, unless it requests and receives prior written authorization from TENNCARE.

2.22.11 Notification to Providers

For purposes of network management, the CONTRACTOR shall, at a minimum, notify all contract providers to file claims associated with covered services directly with the CONTRACTOR, or its subcontractors, on behalf of TennCare enrollees.

2.22.12 Payment Cycle

At a minimum, the CONTRACTOR shall run one (1) provider payment cycle per week, on the same day each week, as determined by the CONTRACTOR and approved in writing by TENNCARE.

2.22.13 Excluded Providers

2.22.13.1 The CONTRACTOR shall not pay any claim submitted by a provider who is excluded from participation in Medicare, Medicaid, or SCHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act or is otherwise not in good standing with TENNCARE.

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- 2.22.13.2 The CONTRACTOR shall not pay any claim submitted by a provider that is on payment hold under the authority of TENNCARE.

2.23 INFORMATION SYSTEMS

2.23.1 General Provisions

2.23.1.1 Systems Functions

The CONTRACTOR shall have Information management processes and Information Systems (hereafter referred to as Systems) that enable it to meet TENNCARE and federal reporting requirements and other Agreement requirements and that are in compliance with this Agreement and all applicable state and federal laws, rules and regulations including HIPAA.

2.23.1.2 Systems Capacity

The CONTRACTOR's Systems shall possess capacity sufficient to handle the workload projected for the start date of operations and shall be scaleable and flexible so they can be adapted as needed, within negotiated time frames, in response to changes in Agreement requirements, increases in enrollment estimates, etc.

2.23.1.3 Electronic Messaging

- 2.23.1.3.1 The CONTRACTOR shall provide a continuously available electronic mail communication link (e-mail system) with TENNCARE.

- 2.23.1.3.2 The e-mail system shall be capable of attaching and sending documents created using software products other than CONTRACTOR's Systems, including TENNCARE's currently installed version of Microsoft Office and any subsequent upgrades as adopted.

- 2.23.1.3.3 As needed, the CONTRACTOR shall be able to communicate with TENNCARE using TENNCARE's e-mail system over a secure virtual private network (VPN).

- 2.23.1.3.4 As needed, based on the sensitivity of data contained in an electronic message, the CONTRACTOR shall support network-to-network encryption of said messages.

2.23.1.4 Participation in Information Systems Work Groups/Committees

The CONTRACTOR and TENNCARE shall establish an information systems work group/committee to coordinate activities and develop cohesive systems strategies among TENNCARE and the MCOs. The Work Group will meet on a designated schedule as agreed to by TENNCARE and the CONTRACTOR.

2.23.1.5 Connectivity to TENNCARE/State Network and Systems

The CONTRACTOR shall be responsible for establishing connectivity to TENNCARE's/the state's wide area data communications network, and the relevant information systems attached to this network, in accordance to all applicable TENNCARE and/or state policies, standards and guidelines.

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2.23.1.6 Systems Refresh Plan

The CONTRACTOR shall provide to TENNCARE an annual Systems refresh plan (see Section 2.30.16). The plan shall outline how Systems within the CONTRACTOR's span of control will be systematically assessed to determine the need to modify, upgrade and/or replace application software, operating hardware and software, telecommunications capabilities, information management policies and procedures, and/or systems management policies and procedures in response to changes in business requirements, technology obsolescence, staff turnover and other relevant factors. The systems refresh plan shall also indicate how the CONTRACTOR will insure that the version and/or release level of all of its Systems components (application software, operating hardware, operating software) are always formally supported by the original equipment manufacturer (OEM), software development firm (SDF), or a third party authorized by the OEM and/or SDF to support the System component.

2.23.2 **Data and Document Management Requirements**

2.23.2.1 Adherence to Data and Document Management Standards

2.23.2.1.1 The CONTRACTOR's Systems shall conform to the data and document management standards by information type/subtype detailed in the HIPAA Implementation and TennCare Companion guides, inclusive of the standard transaction code sets specified in the guides.

2.23.2.1.2 The CONTRACTOR's Systems shall conform to HIPAA standards for data and document management that are currently under development within one-hundred twenty (120) calendar days of the standard's effective date or, if earlier, the date stipulated by CMS or TENNCARE.

2.23.2.2 Data Model and Accessibility

The CONTRACTOR's Systems shall be Structured Query Language (SQL) and/or Open Database Connectivity (ODBC) compliant; alternatively, the CONTRACTOR's Systems shall employ a relational data model in the architecture of its databases in addition to a relational database management system (RDBMS) to operate and maintain said databases.

2.23.2.3 Data and Document Relationships

2.23.2.3.1 When the CONTRACTOR houses indexed images of documents used by members and providers to transact with the CONTRACTOR the CONTRACTOR shall ensure that these documents maintain logical relationships to certain key data such as member identification and provider identification number.

2.23.2.3.2 The CONTRACTOR shall ensure that records associated with a common event, transaction or customer service issue have a common index that will facilitate search, retrieval and analysis of related activities, e.g., interactions with a particular member about a reported problem.

2.23.2.3.3 Upon TENNCARE request, the CONTRACTOR shall be able to generate a listing of all members and providers that were sent a particular document, the date and time that the document was generated, and the date and time that it was sent to particular members or providers or groups thereof. The CONTRACTOR shall also be able to generate a sample of said document.

2.23.2.4 Information Retention

2.23.2.4.1 The CONTRACTOR shall provide and maintain a comprehensive information retention plan that is in compliance with state and federal requirements. The plan shall comply with the applicable requirements of the Tennessee Department of General Services, Records Management Division.

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- 2.23.2.4.2 The CONTRACTOR shall maintain information on-line for a minimum of three (3) years, based on the last date of update activity, and update detailed and summary history data monthly for up to three (3) years to reflect adjustments.
- 2.23.2.4.3 The CONTRACTOR shall provide forty-eight (48) hour turnaround or better on requests for access to information that is between three (3) years and six (6) years old, and seventy-two (72) hour turnaround or better on requests for access to information in machine readable form that is between six (6) and ten (10) years old.
- 2.23.2.4.4 If an audit or administrative, civil or criminal investigation or prosecution is in progress or audit findings or administrative, civil or criminal investigations or prosecutions are unresolved, information shall be kept in electronic form until all tasks or proceedings are completed.

2.23.2.5 Information Ownership

All information, whether data or documents, and reports that contain or make references to said information, involving or arising out of this Agreement is owned by TENNCARE. The CONTRACTOR is expressly prohibited from sharing or publishing TENNCARE information and reports without the prior written consent of TENNCARE.

2.23.3 **System and Data Integration Requirements**

2.23.3.1 Adherence to Standards for Data Exchange

2.23.3.1.1 The CONTRACTOR's Systems shall be able to transmit, receive and process data in HIPAA-compliant or TENNCARE-specific formats and methods, including but not limited to secure File Transfer Protocol (FTP) over a secure connection such as a VPN, that are in use at the start of Systems readiness review activities. These formats are detailed in the HIPAA Implementation and TennCare Companion guides.

2.23.3.1.2 The CONTRACTOR's Systems shall conform to future federal and/or TENNCARE specific standards for data exchange within one-hundred twenty (120) calendar days of the standard's effective date or, if earlier, the date stipulated by CMS or TENNCARE. The CONTRACTOR shall partner with TENNCARE in the management of current and future data exchange formats and methods and in the development and implementation planning of future data exchange methods not specific to HIPAA or other federal effort. Furthermore, the CONTRACTOR shall conform to these standards as stipulated in the plan to implement such standards.

2.23.3.2 HIPAA Compliance Checker

All HIPAA-conforming exchanges of data between TENNCARE and the CONTRACTOR shall be subjected to the highest level of compliance as measured using an industry-standard HIPAA compliance checker application.

2.23.3.3 TENNCARE/State Website/Portal Integration

Where deemed that the CONTRACTOR's Web presence will be incorporated to any degree to TENNCARE's or the state's web presence/portal, the CONTRACTOR shall conform to the applicable TENNCARE or state standards for website structure, coding and presentation.

2.23.3.4 Connectivity to and Compatibility/Interoperability with TENNCARE Systems and IS Infrastructure

2.23.3.4.1 The CONTRACTOR shall be responsible for establishing connectivity to TENNCARE's/the state's wide area data communications network, and the relevant information systems attached to this network, in accordance to all applicable TENNCARE and/or state policies, standards and guidelines.

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2.23.3.4.2 All of the CONTRACTOR's applications, operating software, middleware, and networking hardware and software shall be able to interoperate as needed with TENNCARE and/or state systems and shall conform to applicable standards and specifications set by TENNCARE and/or the state agency that owns the system.

2.23.3.5 Data Exchange in Support of TENNCARE's Program Integrity and Compliance Functions

The CONTRACTOR's System(s) shall be capable of generating files in the prescribed formats for upload into TENNCARE Systems used specifically for program integrity and compliance purposes.

2.23.3.6 Address Standardization

The CONTRACTOR's System(s) shall possess mailing address standardization functionality in accordance with US Postal Service conventions.

2.23.4 **Encounter Data Provision Requirements (Encounter Submission and Processing)**

2.23.4.1 Adherence to HIPAA Standards

The CONTRACTOR's Systems are required to conform to HIPAA-standard transaction code sets as specified in the HIPAA Implementation and TennCare Companion guides.

2.23.4.2 Quality of Submission

2.23.4.2.1 The CONTRACTOR shall submit encounter data that meets established TENNCARE data quality standards. These standards are defined by TENNCARE to ensure receipt of complete and accurate data for program administration and will be closely monitored and strictly enforced. TENNCARE will revise and amend these standards as necessary to ensure continuous quality improvement. The CONTRACTOR shall make changes or corrections to any systems, processes or data transmission formats as needed to comply with TENNCARE data quality standards as originally defined or subsequently amended. The CONTRACTOR shall comply with industry-accepted clean claim standards for all encounter data, including submission of complete and accurate data for all fields required on standard billing forms or electronic claim formats to support proper adjudication of a claim. In the event that the CONTRACTOR denies provider claims for reimbursement due to lack of sufficient or accurate data required for proper adjudication, the CONTRACTOR shall submit all available claim data to TENNCARE without alteration or omission. Where the CONTRACTOR has entered into capitated reimbursement arrangements with providers, the CONTRACTOR shall require submission of all utilization or encounter data to the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims (see Section 2.12.7.31); the CONTRACTOR shall require this submission from providers as a condition of the capitation payment and shall make every effort to enforce this contract provision to ensure timely receipt of complete and accurate data. The CONTRACTOR shall be required to submit all data relevant to the adjudication and payment of claims in sufficient detail, as defined by TENNCARE, in order to support comprehensive financial reporting and utilization analysis. The CONTRACTOR shall submit encounter data according to standards and formats as defined by TENNCARE, complying with standard code sets and maintaining integrity with all reference data sources including provider and member data. All encounter data submissions will be subjected to systematic data quality edits and audits on submission to verify not only the data content but also the accuracy of claims processing. Any batch submission which contains fatal errors that prevent processing or that does not satisfy defined threshold error rates will be rejected and returned to the CONTRACTOR for immediate correction. Due to the need for timely data and to maintain integrity of processing sequence, the CONTRACTOR shall address any issues that prevent processing of an encounter batch in accordance with procedures specified in Section 2.23.13.

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- 2.23.4.2.2 TENNCARE will reject or report individual claims or encounters failing certain edits, as deemed appropriate and necessary by TENNCARE to ensure accurate processing or encounter data quality, and will return these transactions to the CONTRACTOR for research and resolution. TENNCARE will require expeditious action on the part of the CONTRACTOR to resolve errors or problems associated with said claims or the adjudication thereof, including any necessary changes or corrections to any systems, processes or data transmission formats, in accordance with the procedure specified in Section 2.23.13. Generally the CONTRACTOR shall, unless otherwise directed by TENNCARE, address ninety percent (90%) of reported errors within thirty (30) calendar days and address ninety-nine percent (99%) of reported errors within sixty (60) calendar days. Such errors will be considered acceptably addressed when the CONTRACTOR has either confirmed and corrected the reported issue or disputed the reported issue with supporting information or documentation that substantiates the dispute. TENNCARE may require resubmission of the transaction with reference to the original in order to document resolution. Failure to promptly research and address reported errors, including submission of and compliance with an acceptable corrective action plan as required, may result in damages and sanctions as described in Section 2.23.13.
- 2.23.4.3 Provision of Encounter Data
- 2.23.4.3.1 Within two (2) business days of the end of a payment cycle the CONTRACTOR shall generate encounter data files for that payment cycle from its claims management system(s) and/or other sources. If the CONTRACTOR has more than one (1) payment cycle within the same calendar week, the encounter data files may be merged and submitted within two (2) business days of the end of the last payment cycle during the calendar week.
- 2.23.4.3.2 Any encounter data from a subcontractor shall be included in the file from the CONTRACTOR. The CONTRACTOR shall not submit separate encounter files from subcontractors.
- 2.23.4.3.3 The files shall contain settled claims and claim adjustments, including but not limited to adjustments necessitated by payment errors, processed during that payment cycle, as well as encounters processed during that payment cycle from providers with whom the CONTRACTOR has a capitation arrangement.
- 2.23.4.3.4 The level of detail associated with encounters from providers with whom the CONTRACTOR has a capitation arrangement shall be equivalent to the level of detail associated with encounters for which the CONTRACTOR received and settled a fee-for-service claim.
- 2.23.4.3.5 The CONTRACTOR shall adhere to federal and/or TENNCARE payment rules in the definition and treatment of certain data elements, e.g., units of service, that are standard fields in the encounter data submissions and will be treated similarly by TENNCARE across all MCOs.
- 2.23.4.3.6 The CONTRACTOR shall provide encounter data files electronically to TENNCARE in adherence to the procedure and format indicated in the HIPAA Implementation and TennCare Companion guides.
- 2.23.4.3.7 The CONTRACTOR shall institute processes to insure the validity and completeness of the data it submits to TENNCARE. At its discretion, TENNCARE will conduct general data validity and completeness audits using industry-accepted statistical sampling methods. Data elements that will be audited include but are not limited to: member ID, date of service, provider ID (including NPI number and Medicaid I.D. Number), category and sub category (if applicable) of service, diagnosis codes and modifiers, revenue codes, adherence to hard benefit limits, date of claim processing, and date of claim payment. Control totals shall also be reviewed and verified. Additionally, the CONTRACTOR shall reconcile all encounter data submitted to the State to control totals and to the CONTRACTOR's Medical Loss Ratio reports and supply the reconciliation to TENNCARE with each of the Medical Loss Ratio report submissions as specified in Section 2.30.14.2.1.

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2.23.4.3.8 Encounter records shall be submitted such that payment for discrete services which may have been submitted in a single claim can be ascertained in accordance with the CONTRACTOR's applicable reimbursement methodology for that service.

2.23.4.3.9 The CONTRACTOR shall be able to receive, maintain and utilize data extracts from TENNCARE and its contractors, e.g., pharmacy data from TENNCARE or its PBM.

2.23.5 Eligibility and Enrollment Data Exchange Requirements

2.23.5.1 The CONTRACTOR shall receive, process and update enrollment files sent daily by TENNCARE.

2.23.5.2 The CONTRACTOR shall update its eligibility/enrollment databases within twenty-four (24) hours of receipt of said files.

2.23.5.3 The CONTRACTOR shall transmit to TENNCARE, in the formats and methods specified in the HIPAA Implementation and TennCare Companion guides or as otherwise specified by TENNCARE: member address changes, telephone number changes, and PCP.

2.23.5.4 The CONTRACTOR shall be capable of uniquely identifying a distinct TennCare member across multiple populations and Systems within its span of control.

2.23.5.5 The CONTRACTOR shall be able to identify potential duplicate records for a single member and, upon confirmation of said duplicate record by TENNCARE, and resolve the duplication such that the enrollment, service utilization, and customer interaction histories of the duplicate records are linked or merged.

2.23.6 System and Information Security and Access Management Requirements

2.23.6.1 The CONTRACTOR's Systems shall employ an access management function that restricts access to varying hierarchical levels of system functionality and information. The access management function shall:

2.23.6.1.1 Restrict access to information on a "least privilege" basis, e.g., users permitted inquiry privileges only will not be permitted to modify information;

2.23.6.1.2 Restrict access to specific system functions and information based on an individual user profile, including inquiry only capabilities; global access to all functions shall be restricted to specified staff jointly agreed to by TENNCARE and the CONTRACTOR; and

2.23.6.1.3 Restrict unsuccessful attempts to access system functions to three (3), with a system function that automatically prevents further access attempts and records these occurrences.

2.23.6.2 The CONTRACTOR shall make System information available to duly authorized representatives of TENNCARE and other state and federal agencies to evaluate, through inspections or other means, the quality, appropriateness and timeliness of services performed.

2.23.6.3 The CONTRACTOR's Systems shall contain controls to maintain information integrity. These controls shall be in place at all appropriate points of processing. The controls shall be tested in periodic and spot audits following a methodology to be developed jointly by and mutually agreed upon by the CONTRACTOR and TENNCARE.

2.23.6.4 Audit trails shall be incorporated into all Systems to allow information on source data files and documents to be traced through the processing stages to the point where the information is finally recorded. The audit trails shall:

2.23.6.4.1 Contain a unique log-on or terminal ID, the date, and time of any create/modify/delete action and, if applicable, the ID of the system job that effected the action;

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- 2.23.6.4.2 Have the date and identification “stamp” displayed on any on-line inquiry;
- 2.23.6.4.3 Have the ability to trace data from the final place of recording back to its source data file and/or document;
- 2.23.6.4.4 Be supported by listings, transaction reports, update reports, transaction logs, or error logs;
- 2.23.6.4.5 Facilitate auditing of individual records as well as batch audits; and
- 2.23.6.4.6 Be maintained online for no less than two (2) years; additional history shall be retained for no less than ten (10) years and shall be retrievable within 48 hours.
- 2.23.6.5 The CONTRACTOR’s Systems shall have inherent functionality that prevents the alteration of finalized records.
- 2.23.6.6 The CONTRACTOR shall provide for the physical safeguarding of its data processing facilities and the systems and information housed therein. The CONTRACTOR shall provide TENNCARE with access to data facilities upon request. The physical security provisions shall be in effect for the life of this Agreement.
- 2.23.6.7 The CONTRACTOR shall restrict perimeter access to equipment sites, processing areas, and storage areas through a card key or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access.
- 2.23.6.8 The CONTRACTOR shall include physical security features designed to safeguard processor site(s) through required provision of fire retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel.
- 2.23.6.9 The CONTRACTOR shall put in place procedures, measures and technical security to prohibit unauthorized access to the regions of the data communications network inside of a CONTRACTOR’s span of control. This includes but is not limited to: no provider or member service applications shall be directly accessible over the Internet and shall be appropriately isolated to ensure appropriate access.
- 2.23.6.10 The CONTRACTOR shall ensure that remote access users of its Systems can only access said Systems through two-factor user authentication and via methods such as Virtual Private Network (VPN), which must be prior approved in writing by TENNCARE.
- 2.23.6.11 The CONTRACTOR shall comply with recognized industry standards governing security of state and federal automated data processing systems and information processing. At a minimum, the CONTRACTOR shall conduct a security risk assessment and communicate the results in an information security plan provided prior to the start date of operations. The risk assessment shall also be made available to appropriate federal agencies.

2.23.7 Systems Availability, Performance and Problem Management Requirements

- 2.23.7.1 The CONTRACTOR shall ensure that critical member and provider Internet and/or telephone-based functions and information, including but not limited to Confirmation of MCO Enrollment (CME), ECM, and self-service customer service functions are available to the applicable System users twenty-four (24) hours a day, seven (7) days a week, except during periods of scheduled System unavailability agreed upon by TENNCARE and the CONTRACTOR. Unavailability caused by events outside of a CONTRACTOR’s span of control is outside of the scope of this requirement.
- 2.23.7.2 The CONTRACTOR shall ensure that at a minimum all other System functions and information are available to the applicable system users between the hours of 7 a.m. and 7 p.m., in the time zone applicable to the Grand Region being served (for the Middle Grand Region, the applicable time zone shall be Central Time), Monday through Friday.

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- 2.23.7.3 The CONTRACTOR shall ensure that the systems and processes within its span of control associated with its data exchanges with TENNCARE are available and operational according to specifications and the data exchange schedule.
- 2.23.7.4 In the event of a declared major failure or disaster, the CONTRACTOR's core eligibility/enrollment and claims processing systems shall be back online within seventy-two (72) hours of the failure's or disaster's occurrence.
- 2.23.7.5 Upon discovery of any problem within its span of control that may jeopardize or is jeopardizing the availability and performance of critical systems functions and the availability of critical information as defined in this Section of the Agreement, including any problems impacting scheduled exchanges of data between the CONTRACTOR and TENNCARE, the CONTRACTOR shall notify the applicable TennCare staff via phone, fax and/or electronic mail within sixty (60) minutes of such discovery. In its notification the CONTRACTOR shall explain in detail the impact to critical path processes such as enrollment management and encounter submission processes.
- 2.23.7.6 Where the problem results in delays in report distribution or problems in on-line access to critical systems functions and information during a business day, the CONTRACTOR shall notify the applicable TENNCARE staff within fifteen (15) minutes of discovery of the problem, in order for the applicable work activities to be rescheduled or handled based on System unavailability protocols.
- 2.23.7.7 The CONTRACTOR shall provide to appropriate TENNCARE staff information on System unavailability events, as well as status updates on problem resolution. At a minimum these updates shall be provided on an hourly basis and made available via electronic mail and/or telephone.
- 2.23.7.8 The CONTRACTOR shall resolve unscheduled System unavailability of CME and ECM functions, caused by the failure of systems and telecommunications technologies within the CONTRACTOR's span of control, and shall implement the restoration of services, within sixty (60) minutes of the official declaration of System unavailability. Unscheduled System unavailability to all other CONTRACTOR System functions caused by systems and telecommunications technologies within the CONTRACTOR's span of control shall be resolved, and the restoration of services implemented, within eight (8) hours of the official declaration of System unavailability.
- 2.23.7.9 Cumulative System unavailability caused by systems and/or IS infrastructure technologies within the CONTRACTOR's span of control shall not exceed twelve (12) hours during any continuous twenty (20) business day period.
- 2.23.7.10 The CONTRACTOR shall not be responsible for the availability and performance of systems and IS infrastructure technologies outside of the CONTRACTOR's span of control.
- 2.23.7.11 Within five (5) business days of the occurrence of a problem with system availability, the CONTRACTOR shall provide TENNCARE with full written documentation that includes a corrective action plan describing how the CONTRACTOR will prevent the problem from occurring again.
- 2.23.7.12 Business Continuity and Disaster Recovery (BC-DR) Plan
- 2.23.7.12.1 Regardless of the architecture of its Systems, the CONTRACTOR shall develop and be continually ready to invoke a BC-DR plan that is reviewed and prior approved in writing by TENNCARE.
- 2.23.7.12.2 At a minimum the CONTRACTOR's BC-DR plan shall address the following scenarios: (a) the central computer installation and resident software are destroyed or damaged, (b) System interruption or failure resulting from network, operating hardware, software, or operational

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errors that compromises the integrity of transactions that are active in a live system at the time of the outage, (c) System interruption or failure resulting from network, operating hardware, software or operational errors that compromises the integrity of data maintained in a live or archival system, and (d) System interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system but does prevent access to the System, i.e., causes unscheduled System unavailability.

2.23.7.12.3 The CONTRACTOR's BC-DR plan shall specify projected recovery times and data loss for mission-critical Systems in the event of a declared disaster.

2.23.7.12.4 The CONTRACTOR shall periodically, but no less than annually, test its BC-DR plan through simulated disasters and lower level failures in order to demonstrate to TENNCARE that it can restore System functions per the standards outlined elsewhere in this Section, Section 2.23 of the Agreement.

2.23.7.12.5 The CONTRACTOR shall submit a baseline BC-DR plan to TENNCARE and communicate proposed modifications as required in Section 2.30.16.

2.23.8 System User and Technical Support Requirements

2.23.8.1 The CONTRACTOR shall provide Systems Help Desk (SHD) services to all TENNCARE staff and the other agencies that may have direct access to CONTRACTOR systems.

2.23.8.2 The CONTRACTOR's SHD shall be available via local and toll-free telephone service and via e-mail from 7 a.m. to 7 p.m., in the time zone applicable to the Grand Region being served (for the Middle Grand Region, the applicable time zone shall be Central Time), Monday through Friday, with the exception of State of Tennessee holidays. Upon TENNCARE request, the CONTRACTOR shall staff the SHD on a state holiday, Saturday, or Sunday.

2.23.8.3 The CONTRACTOR's SHD staff shall answer user questions regarding CONTRACTOR System functions and capabilities; report recurring programmatic and operational problems to appropriate CONTRACTOR or TENNCARE staff for follow-up; redirect problems or queries that are not supported by the SHD, as appropriate, via a telephone transfer or other agreed upon methodology; and redirect problems or queries specific to data access authorization to the appropriate TENNCARE login account administrator.

2.23.8.4 The CONTRACTOR shall ensure individuals who place calls to the SHD between the hours of 7 p.m. and 7 a.m., in the time zone applicable to the Grand Region being served (for the Middle Grand Region, the applicable time zone shall be Central Time), shall be able to leave a message. The CONTRACTOR's SHD shall respond to messages by noon the following business day.

2.23.8.5 The CONTRACTOR shall ensure recurring problems not specific to System unavailability identified by the SHD shall be documented and reported to CONTRACTOR management within one (1) business day of recognition so that deficiencies are promptly corrected.

2.23.8.6 The CONTRACTOR shall have an IS service management system that provides an automated method to record, track and report on all questions and/or problems reported to the SHD.

2.23.9 System Testing and Change Management Requirements

2.23.9.1 The CONTRACTOR shall notify the applicable TENNCARE staff person of the following changes to Systems within its span of control within at least ninety (90) calendar days of the projected date of the change.

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- 2.23.9.1.1 Major changes, upgrades, modifications or updates to application or operating software associated with the following core production Systems: claims processing, eligibility and enrollment processing, service authorization management, provider enrollment and data management, and encounter data management; and
- 2.23.9.1.2 Conversions of core transaction management Systems.
- 2.23.9.2 If so directed by TENNCARE, the CONTRACTOR shall discuss the proposed change in the Systems work group.
- 2.23.9.3 The CONTRACTOR shall respond to TENNCARE notification of System problems not resulting in System unavailability according to the following time frames:
 - 2.23.9.3.1 Within five (5) calendar days of receiving notification from TENNCARE the CONTRACTOR shall respond in writing to notices of system problems.
 - 2.23.9.3.2 Within fifteen (15) calendar days, the correction shall be made or a requirements analysis and specifications document will be due.
 - 2.23.9.3.3 The CONTRACTOR shall correct the deficiency by an effective date to be determined by TENNCARE.
 - 2.23.9.3.4 The CONTRACTOR's Systems shall have a system-inherent mechanism for recording any change to a software module or subsystem.
 - 2.23.9.3.5 The CONTRACTOR shall put in place procedures and measures for safeguarding against unauthorized modifications to CONTRACTOR Systems.
- 2.23.9.4 Valid Window for Certain System Changes

Unless otherwise agreed to in advance by TENNCARE as part of the activities described in this Section 2.23.9, the CONTRACTOR shall not schedule System unavailability to perform System maintenance, repair and/or upgrade activities to take place during hours that can compromise or prevent critical business operations.
- 2.23.9.5 Testing
 - 2.23.9.5.1 The CONTRACTOR shall work with TENNCARE pertaining to any testing initiative as required by TENNCARE.

2.23.10 Information Systems Documentation Requirements

- 2.23.10.1 The CONTRACTOR shall ensure that written System process and procedure manuals document and describe all manual and automated system procedures for its information management processes and information systems.
- 2.23.10.2 The CONTRACTOR shall develop, prepare, print, maintain, produce, and distribute to TENNCARE distinct System design and management manuals, user manuals and quick/reference guides, and any updates.
- 2.23.10.3 The CONTRACTOR's System user manuals shall contain information about, and instructions for, using applicable System functions and accessing applicable system data.
- 2.23.10.4 When a System change is subject to TENNCARE prior written approval, the CONTRACTOR shall submit revisions to the appropriate manuals for prior written approval before implementing said System changes.

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2.23.10.5 All of the aforementioned manuals and reference guides shall be available in printed form and/or on-line. If so prescribed, the manuals shall be published in accordance to the appropriate TENNCARE and/or TENNCARE standard.

2.23.10.6 The CONTRACTOR shall update the electronic version of these manuals immediately; updates to the printed version of these manuals shall occur within ten (10) business days of the update taking effect.

2.23.11 **Reporting Requirements (Specific to Information Management and Systems Functions and Capabilities)**

2.23.11.1 The CONTRACTOR shall comply with all reporting requirements as described in Section 2.30.16 of this Agreement.

2.23.11.2 The CONTRACTOR shall provide systems-based capabilities for access by authorized TENNCARE personnel, on a secure and read-only basis, to data that can be used in ad hoc reports.

2.23.12 **Other Requirements**

2.23.12.1 Statewide Data Warehouse Requirements

The CONTRACTOR shall participate in a statewide effort to tie all hospitals, physicians, and other providers' information into a data warehouse that shall include, but not be limited to, claims information, formulary information, medically necessary service information, cost sharing information and a listing of providers by specialty for each MCO.

2.23.12.2 Community Health Record for TennCare Enrollees (Electronic Medical Record)

2.23.12.2.1 At such time that TENNCARE requires, the CONTRACTOR shall participate and cooperate with TennCare to implement, within a reasonable time frame, a secure, Web-accessible community health record for TennCare enrollees.

2.23.12.2.2 The design of the Web site for accessing the community health record and the record format and design shall comply with HIPAA, other federal and all state privacy and confidentiality regulations.

2.23.12.2.3 The CONTRACTOR shall provide a Web-based access vehicle for contract providers to the System described in Section 2.23.12.2.1, and shall work with said providers to encourage adoption of this System.

2.23.13 **Corrective Actions, Liquidated Damages and Sanctions Related to Information Systems**

2.23.13.1 Within five (5) business days of receipt of notice from TENNCARE of the occurrence of a problem with the provision and/or intake of an encounter or enrollment file, the CONTRACTOR shall provide TENNCARE with full written documentation that includes acknowledgement of receipt of the notice, a corrective action plan describing how the CONTRACTOR has addressed or will address the immediate problem and how the CONTRACTOR shall prevent the problem from recurring. In the event that the CONTRACTOR fails to correct errors which prevent processing of encounter or enrollment data in a timely manner as required by TENNCARE, fails to submit a corrective action plan as requested or required, or fails to comply with an accepted corrective action plan, TENNCARE may assess liquidated damages as specified in Section 5.8. Continued or repeated failure to submit clean encounter data may result in the application of additional damages or sanctions or be considered a breach of the Agreement.

2.23.13.2 Individual records submitted by the CONTRACTOR may be rejected; these records, once errors therein have been corrected, shall be resubmitted by the CONTRACTOR as stipulated by TENNCARE. In the event that the CONTRACTOR is unable to research or address

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reported errors in a timely manner as required by TENNCARE, the CONTRACTOR shall submit to TENNCARE a corrective action plan describing how the CONTRACTOR will research and address the errors and how the CONTRACTOR shall prevent the problem from recurring within five (5) business days of receipt of notice from TENNCARE that individual records submitted by the CONTRACTOR have been rejected. In the event that the CONTRACTOR fails to address or resolve problems with individual records in a timely manner as required by TENNCARE, which shall include failure to submit a corrective action plan as requested or required, or failure to comply with an accepted corrective action plan, TENNCARE may assess liquidated damages as specified in Section 5.8. Continued or repeated failure to address reported errors may result in additional damages or sanctions or be considered a breach of the Agreement.

- 2.23.13.3 In the event that the CONTRACTOR fails to demonstrate in the tests of its BC-DR plan that it can restore system functions per the standards outlined in this Agreement, the CONTRACTOR shall submit to TENNCARE a corrective action plan that describes how the failure will be resolved. The corrective action plan shall be delivered within five (5) business days of the conclusion of the test.

2.24 ADMINISTRATIVE REQUIREMENTS

2.24.1 General Responsibilities

- 2.24.1.1 TENNCARE shall be responsible for management of this Agreement. Management shall be conducted in good faith with the best interest of the State and the citizens it serves being the prime consideration. Management of TennCare shall be conducted in a manner consistent with simplicity of administration and the best interests of enrollees, as required by 42 USC 1396a(a)(19).
- 2.24.1.2 The CONTRACTOR shall be responsible for complying with the requirements of this Agreement and shall act in good faith in the performance of the requirements of this Agreement.
- 2.24.1.3 The CONTRACTOR shall develop policies and procedures that describe, in detail, how the CONTRACTOR will comply with the requirements of this Agreement and, as applicable, are specific to the Grand Region covered by this Agreement, and the CONTRACTOR shall administer this Agreement in accordance with those policies and procedures unless otherwise directed or approved in writing by TENNCARE.
- 2.24.1.4 It is recognized that TennCare Select medical management procedures may differ from the CONTRACTOR's medical management procedures utilized for operations under the "TennCare Contractor Risk Agreement" in order to recognize the unique populations served by this Agreement. To the extent that TennCare Select medical management procedures are different from the CONTRACTOR's "TennCare Contractor Risk Agreement" medical management procedures, the CONTRACTOR shall obtain written approval from TENNCARE unless otherwise directed or approved by TENNCARE.
- 2.24.1.5 The CONTRACTOR shall submit policies and procedures and other deliverables specified by TENNCARE to TENNCARE for review and/or written approval in the format and within the time frames specified by TENNCARE. The CONTRACTOR shall make any changes requested by TENNCARE to policies and procedures or other deliverables and in the time frames specified by TENNCARE.
- 2.24.1.6 As provided in this Agreement, should the CONTRACTOR have a question on policy determinations, benefits, or operating guidelines required for proper performance of the CONTRACTOR's responsibilities, the CONTRACTOR shall request a determination from TENNCARE in writing.

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2.24.2 Behavioral Health Advisory Committee

The CONTRACTOR shall establish a behavioral health advisory committee that is accountable to the CONTRACTOR's governing body to provide input and advice regarding all aspects of the provision of behavioral health services according to the following requirements:

- 2.24.2.1 The CONTRACTOR's behavioral health advisory committee shall be comprised of at least fifty-one percent (51%) consumer and family representatives, of which the majority shall include families of adults with serious and/or persistent mental illness (SPMI) and families of children with serious emotional disturbance (SED);
- 2.24.2.2 There shall be geographic diversity;
- 2.24.2.3 There shall be cultural and racial diversity;
- 2.24.2.4 There shall be representation by providers and consumers (or family members of consumers) of substance abuse services;
- 2.24.2.5 At a minimum, the CONTRACTOR's behavioral health advisory committee shall have input into policy development, planning for services, service evaluation, and member, family member and provider education;
- 2.24.2.6 Meetings shall be held at least quarterly;
- 2.24.2.7 Travel costs shall be paid by the CONTRACTOR;
- 2.24.2.8 The CONTRACTOR shall report on the activities of the CONTRACTOR's behavioral health advisory committee as required in Section 2.30.17; and
- 2.24.2.9 The CONTRACTOR, as membership changes, shall submit current membership lists to the State.

2.24.3 Performance Standards

The CONTRACTOR agrees TENNCARE may assess liquidated damages for failure to meet the performance standards specified in Attachment XV.

2.24.4 Medical Records Requirements

- 2.24.4.1 The CONTRACTOR shall maintain, and shall require contract providers and subcontractors to maintain, medical records in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review, administrative, civil and/or criminal investigations and/or prosecutions.
- 2.24.4.2 The CONTRACTOR shall have medical record keeping policies and practices which are consistent with 42 CFR Part 456 and current NCQA standards for medical record documentation. The CONTRACTOR shall distribute these policies to practice sites. At a minimum, the policies and procedures shall address:
 - 2.24.4.2.1 Confidentiality of medical records;
 - 2.24.4.2.2 Medical record documentation standards; and
 - 2.24.4.2.3 The medical record keeping system and standards for the availability of medical records. At a minimum the following shall apply:
 - 2.24.4.2.3.1 Medical records shall be maintained or available at the site where covered services are rendered;

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- 2.24.4.2.3.2 Enrollees (for purposes of behavioral health records, enrollee includes an individual who is age sixteen (16) or over) and their legally appointed representatives shall be given access to the enrollees' medical records, to the extent and in the manner provided by TCA 63-2-101, 63-2-102 and 33-3-104 *et seq.*, and, subject to reasonable charges, (except as provided in Section 2.24.4.2.3.3. below) be given copies thereof upon request;
- 2.24.4.2.3.3 Provisions for ensuring that, in the event a patient-provider relationship with a TennCare primary care provider ends and the enrollee requests that medical records be sent to a second TennCare provider who will be the enrollee's primary care provider, the first provider does not charge the enrollee or the second provider for providing the medical records; and
- 2.24.4.2.3.4 Performance goals to assess the quality of medical record keeping.
- 2.24.4.2.4 The CONTRACTOR shall maintain and require contract behavioral health providers to maintain medical records in conformity with TCA 33-3-101 *et seq.* for persons with serious emotional disturbance or mental illness.
- 2.24.4.2.5 The CONTRACTOR shall maintain and require contract behavioral health providers to maintain medical records of persons whose confidentiality is protected by 42 CFR Part 2 in conformity with that rule or TCA 33-3-103, whichever is more stringent.

2.24.5 Location of Non-Responsive TennCare Eligibles

The CONTRACTOR agrees to attempt to locate "non-responsive TennCare eligibles" that have been enrolled in the CONTRACTOR's plan. Non-responsive TennCare eligibles are persons identified by TennCare who have not responded to re-verification attempts and who have not (and whose family members have not) accessed services during the period of review. Within 90 days of identification, the CONTRACTOR shall attempt to reach each non-responsive TennCare eligible identified by TennCare to the CONTRACTOR and assigned to TennCare Select effective July 1, 2001. The CONTRACTOR shall attempt to reach each non-responsive TennCare eligible telephonically using the phone number provided by TennCare. Upon placement of the call, if the CONTRACTOR receives a message that the phone number has been changed, the CONTRACTOR shall update the enrollee's phone number in its system and make at least three documented attempts to contact said enrollee at the new number to obtain the enrollee's new address. If successful, the CONTRACTOR will forward this information to TennCare via the Weekly Enrollee Information Report as well as a Non-Responsive File via CD Rom which shall include additional data elements as described in this Section. If TennCare does not provide a telephone number, the CONTRACTOR shall make and document at least one attempt to contact the non-responsive TennCare eligible through other publicly available information resources. In addition, the CONTRACTOR shall monitor claims activity for non-responsive TennCare eligibles. In the event the CONTRACTOR receives a claim for payment on behalf of a non-responsive TennCare eligible, the CONTRACTOR shall contact the provider and request the enrollee's phone number and address on file with the provider. The CONTRACTOR shall make at least three documented attempts to contact the enrollee at the location provided by the provider to confirm the enrollee's address. Once confirmed, the CONTRACTOR shall forward this information to TennCare via the Weekly Enrollee Information Report as well as a Non-Responsive File via CD Rom which shall include additional data elements as described in this Section. The CONTRACTOR shall complete this process within 45 days for other non-responsive TennCare eligible as they are identified by TennCare to the CONTRACTOR.

2.25 MONITORING

2.25.1 General

- 2.25.1.1 TENNCARE, in its daily activities, shall monitor the CONTRACTOR for compliance with the provisions of this Agreement.
- 2.25.1.2 TENNCARE, CMS, or their representatives shall at least annually monitor the operation of the CONTRACTOR for compliance with the provisions of this Agreement and applicable federal and state laws and regulations. Monitoring activities shall include, but not be limited

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to, inspection of the CONTRACTOR's facilities, auditing and/or review of all records developed under this Agreement including periodic medical audits, appeals, enrollments, disenrollments, termination of providers, utilization and financial records, reviewing management systems and procedures developed under this Agreement and review of any other areas or materials relevant to or pertaining to this Agreement. TENNCARE will emphasize case record validation because of the importance of having accurate service utilization data for program management, utilization review and evaluation purposes.

- 2.25.1.3 TENNCARE shall prepare a report of its findings and recommendations and require the CONTRACTOR to develop corrective action plans as appropriate.

2.25.2 Facility Inspection

TENNCARE, CMS, or their representatives may conduct on-site inspections of all health facilities and service delivery sites to be utilized by the CONTRACTOR in fulfilling the obligations under this Agreement. Inspections may be made at anytime during the Agreement period and without prior notice.

2.25.3 Inspection of Work Performed

TENNCARE, CMS, or their representatives shall, at all reasonable times, have the right to enter into the CONTRACTOR's premises, or such other places where duties of this Agreement are being performed, to inspect, monitor, or otherwise evaluate including periodic audits of the work being performed. The CONTRACTOR and all other subcontractors or providers shall supply reasonable access to all facilities and assistance for TENNCARE's representatives. All inspections and evaluations shall be performed in such a manner as to minimize disruption of normal business.

2.25.4 Approval Process

- 2.25.4.1 As specified by TENNCARE, TENNCARE must approve various deliverables/items before they can be implemented by the CONTRACTOR.
- 2.25.4.2 At any time that approval of TENNCARE is required in this Agreement, such approval shall not be considered granted unless TENNCARE issues its approval in writing.
- 2.25.4.3 TENNCARE shall specify the deliverables (see Attachment XIII) to be submitted to TENNCARE, whether they require prior approval or not, deliverable instructions, submission and approval time frames, and technical assistance as required.
- 2.25.4.4 Should TENNCARE not respond to a submission of a deliverable in the amount of time agreed to by TENNCARE, the CONTRACTOR shall not be penalized with either liquidated damages or a withhold as a result of implementing the item awaiting approval. However, failure by TENNCARE to assess liquidated damages or withholds shall not preclude TENNCARE from requiring the CONTRACTOR to rescind or modify the item if it is determined by TENNCARE to be in the best interest of the TennCare program.

2.25.5 Availability of Records

- 2.25.5.1 The CONTRACTOR shall ensure within its own organization and pursuant to any agreement the CONTRACTOR may have with any other providers of service, including, but not limited to providers, subcontractors or any person or entity receiving monies directly or indirectly by or through TennCare, that TENNCARE representatives and authorized federal, state and Office of the Comptroller of the Treasury personnel, including, but not limited to TENNCARE, the Office of the Inspector General (OIG), the Tennessee Bureau of Investigations, Medicaid Fraud Control Unit (TBI MFCU), the Department of Health and Human Services, Office of Inspector General (DHHS OIG) and the Department of Justice (DOJ), and any other duly authorized state or federal agency shall have immediate and complete access to all records pertaining to services provided to TennCare enrollees.

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- 2.25.5.2 The CONTRACTOR and its subcontractors and any providers of service, including, but not limited to providers or any person or entity receiving monies directly or indirectly by or through TennCare shall make all records (including but not limited to, financial and medical records) available at the CONTRACTOR's, provider's, and/or the subcontractor's expense for administrative, civil and/or criminal review, audit, or evaluation, inspection, investigation and/or prosecution by authorized federal, state, and Office of the Comptroller of the Treasury personnel, including representatives from the OIG, the TBI MFCU, DOJ and the DHHS OIG, TENNCARE or any duly authorized state or federal agency. Access will be either through on-site review of records or through the mail at the government agency's discretion and during normal business hours, unless there are exigent circumstances, in which case access will be at any time. The CONTRACTOR shall send all records to be sent by mail to TENNCARE within twenty (20) business days of request unless otherwise specified by TENNCARE or TennCare rules and regulations. Requested records shall be provided at no expense to TENNCARE, authorized federal, state, and Office of the Comptroller of the Treasury personnel, including representatives from the OIG, the TBI MFCU, DOJ and the DHHS OIG, or any duly authorized state or federal agency. Records related to appeals shall be forwarded within the time frames specified in the appeal process portion of this Agreement. Such requests made by TENNCARE shall not be unreasonable.
- 2.25.5.3 The CONTRACTOR and any of its subcontractors, providers or any entity or person directly or indirectly receiving monies originating from TennCare, shall make all records, including, but not limited to, financial, administrative and medical records available to any duly authorized government agency, including but not limited to TENNCARE, OIG, TBI MFCU, DHHS OIG and DOJ, upon any authorized government agency's request. Any authorized government agency, including but not limited to OIG, TBI MFCU, DHHS OIG and DOJ, may use these records to carry out their authorized duties, reviews, audits, administrative, civil and/or criminal investigations and/or prosecutions.
- 2.25.5.4 The CONTRACTOR, any CONTRACTOR's management company and any CONTRACTOR's claims processing subcontractor shall cooperate with the State, or any of the State's contractors and agents, including, but not limited to TENNCARE, OIG, TBI MFCU, DOJ and the DHHS OIG, and the Office of the Comptroller of the Treasury, and any duly authorized governmental agency, during the course of any claims processing, financial or operational examinations or during any administrative, civil or criminal investigation, hearing or prosecution. This cooperation shall include, but shall not be limited to the following:
- 2.25.5.4.1 Providing full cooperation and direct and unrestricted access to facilities, information, and staff, including facilities, information and staff of any management company or subcontractor, to the State or any of the State's contractors and agents, which includes, but is not limited to TENNCARE, OIG, TBI MFCU, DOJ and the DHHS OIG, and the Office of the Comptroller of the Treasury and any duly authorized governmental agency, including federal agencies; and
- 2.25.5.4.2 Maintaining full cooperation and open authority for claims processing systems access and mailroom visits by TDCI or designated representatives or any authorized entity of the state or federal government, and to cooperate fully with detail claims testing for claims processing system compliance.
- 2.25.5.5 The CONTRACTOR shall cooperate fully with audits the State may conduct of medical management to include clinical processes and outcomes, internal audits, provider networks, and any other aspect of the program the State deems appropriate. The State may select any qualified person or organization to conduct the audits.

2.25.6 **Audit Requirements**

The CONTRACTOR and its providers, subcontractors and other entities receiving monies originating by or through TennCare shall maintain books, records, documents, and other evidence pertaining to services rendered, equipment, staff, financial records, medical records, and the administrative costs and expenses incurred pursuant to this Agreement as well as medical information relating to the individual enrollees as required for the purposes of audit, or administrative, civil and/or criminal investigations and/or prosecution

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or for the purposes of complying with the requirements set forth in Section 2.20 of this Agreement. Records other than medical records may be kept in an original paper state or preserved on micromedia or electronic format. Medical records shall be maintained in their original form or may be converted to electronic format as long as the records are readable and/or legible. These records, books, documents, etc., shall be available for any authorized federal, state, including, but not limited to TENNCARE, OIG, TBI MFCU, DOJ and the DHHS OIG, and Office of the Comptroller of the Treasury personnel during the Agreement period and five (5) years thereafter, unless an audit, administrative, civil or criminal investigation or prosecution is in progress or audit findings or administrative, civil or criminal investigations or prosecutions are yet unresolved in which case records shall be kept until all tasks or proceedings are completed. During the Agreement period, these records shall be available at the CONTRACTOR's chosen location in Tennessee subject to the written approval of TENNCARE. If the records need to be sent to TENNCARE, the CONTRACTOR shall bear the expense of delivery. Prior approval of the disposition of CONTRACTOR, subcontractor or provider records must be requested and approved by TENNCARE in writing. Nothing in this Section shall be construed to modify or change the obligations of the CONTRACTOR contained in Section 2.23.2 (Data and Document Management Requirements), 2.23.3 (System and Data Integration Requirements), or 2.23.6 (Security and Access Management Requirements) of this Agreement.

2.25.7 **Independent Review of the CONTRACTOR**

2.25.7.1 The CONTRACTOR shall cooperate fully with TENNCARE's External Quality Review Organization (EQRO) which will conduct a periodic and/or an annual independent review of the CONTRACTOR.

2.25.7.2 The CONTRACTOR shall cooperate fully with any evaluation of the TennCare program conducted by CMS.

2.25.8 **Accessibility for Monitoring**

For purposes of monitoring under this Agreement, the CONTRACTOR shall make available to TENNCARE or its representative and other authorized state and federal personnel, all records, books, documents, and other evidence pertaining to this Agreement, as well as appropriate administrative and/or management personnel who administer the MCO. The monitoring shall occur periodically during the Agreement period and may include announced or unannounced visits, or both.

2.25.9 **Corrective Action Requirements**

2.25.9.1 If TENNCARE determines that the CONTRACTOR is not in compliance with one or more requirements of this Agreement, TENNCARE will issue a notice of deficiency identifying the deficiency(ies), follow-up recommendations/requirements (e.g., a request for a corrective action plan), and time frames for follow-up.

2.25.9.2 Upon receipt of a notice of deficiency(ies) from TENNCARE, the CONTRACTOR shall comply with all recommendations/requirements made in writing by TENNCARE within the time frames specified by TENNCARE.

2.25.9.3 The CONTRACTOR shall be responsible for ensuring corrective action when a subcontractor or provider is not in compliance with the Agreement.

2.26 **SUBCONTRACTS**

2.26.1 **Subcontract Relationships and Delegation**

If the CONTRACTOR delegates responsibilities to a subcontractor, the CONTRACTOR shall ensure that the subcontracting relationship and subcontracting document(s) comply with federal requirements, including, but not limited to, compliance with the applicable provisions of 42 CFR 438.230(b) and 42 CFR 434.6 as described below:

2.26.1.1 The CONTRACTOR shall evaluate the prospective subcontractor's ability to perform the activities to be delegated;

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- 2.26.1.2 The CONTRACTOR shall require that the agreement be in writing and specify the activities and report responsibilities delegated to the subcontractor and provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate;
- 2.26.1.3 The CONTRACTOR shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review, on at least an annual basis, consistent with NCQA standards and state MCO laws and regulations;
- 2.26.1.4 The CONTRACTOR shall identify deficiencies or areas for improvement, and the CONTRACTOR and the subcontractor shall take corrective action as necessary; and
- 2.26.1.5 If the subcontract is for purposes of providing or securing the provision of covered services to enrollees, the CONTRACTOR shall ensure that all requirements described in Section 2.12 of this Agreement are included in the subcontract and/or a separate provider agreement executed by the appropriate parties.

2.26.2 Legal Responsibility

The CONTRACTOR shall be responsible for the administration and management of all aspects of this Agreement and the MCO covered thereunder including all subcontracts/subcontractors. The CONTRACTOR shall ensure that the subcontractor shall not enter into any subsequent agreements or subcontracts for any of the work contemplated under the subcontractor for purposes of this Agreement without prior written approval of the CONTRACTOR. No subcontract, provider agreement or other delegation of responsibility terminates or reduces the legal responsibility of the CONTRACTOR to TENNCARE to ensure that all activities under this Agreement are carried out in compliance with the Agreement.

2.26.3 Prior Approval

All subcontracts, as defined in Section 1 of this Agreement, and revisions thereto shall be approved in advance in writing by TENNCARE. The CONTRACTOR shall revise subcontracts as directed by TENNCARE. Approval of subcontracts shall not be considered granted unless TENNCARE issues its approval in writing. Once a subcontract has been executed by all of the participating parties, a copy of the fully executed subcontract shall be sent to TENNCARE within thirty (30) calendar days of execution. This written prior approval requirement does not relieve the CONTRACTOR of any responsibilities to submit all proposed material modifications of the CONTRACTOR's MCO operations to TDCI for prior review and approval as required by Title 56, Chapter 32, Part 1.

2.26.4 Subcontracts for Behavioral Health Services

If the CONTRACTOR subcontracts for the provision or management of behavioral health services, the subcontract shall be specific to the TennCare program, and the CONTRACTOR shall comply with the requirements in Section 2.6.1.2 regarding integration of physical health and behavioral health services.

2.26.5 Standards

The CONTRACTOR shall require and ensure that the subcontractor complies with all applicable requirements in this Agreement. This includes, but is not limited to, Sections 2.19, 2.21.6, 2.25.5, 2.25.6, 2.25.8, 2.25.9, 5.1, 5.7, 5.20, and 5.21 of this Agreement.

2.26.6 Quality of Care

If the subcontract is for the purpose of securing the provision of covered services, the subcontract shall specify that the subcontractor adhere to the quality requirements the CONTRACTOR is held to.

2.26.7 Interpretation/Translation Services and Limited English Proficiency (LEP) Provisions

The CONTRACTOR shall provide instruction for all direct service subcontractors regarding the CONTRACTOR's written procedure for the provision of language interpretation and translation services for any member who needs such services, including but not limited to, enrollees with Limited English Proficiency.

2.26.8 Children in State Custody

The CONTRACTOR shall include in its subcontracts a provision stating that subcontractors are not permitted to encourage or suggest, in any way, that TennCare children be placed into state custody in order to receive medical or behavioral health services covered by TENNCARE.

2.26.9 Assignability

Transportation and claims processing subcontracts shall include language requiring that the subcontract agreement shall be assignable from the CONTRACTOR to the State, or its designee: i) at the State's discretion upon written notice to the CONTRACTOR and the affected subcontractor; or ii) upon CONTRACTOR's request and written approval by the State. Further, the subcontract agreement shall include language by which the subcontractor agrees to be bound by any such assignment, and that the State, or its designee, shall not be responsible for past obligations of the CONTRACTOR.

2.26.10 Claims Processing

2.26.10.1 All claims for services furnished to a TennCare enrollee filed with a CONTRACTOR shall be processed by either the CONTRACTOR or by one (1) subcontractor retained by the organization for the purpose of processing claims. However, another entity can process claims related to behavioral health vision, lab or transportation if that entity has been retained by the CONTRACTOR to arrange and provide for the delivery of said services. However, all claims processed by any subcontractor shall be maintained and submitted by the CONTRACTOR.

2.26.10.2 As required in Section 2.30.18 of this Agreement, where the CONTRACTOR has subcontracted claims processing for TennCare claims, the CONTRACTOR shall provide to TENNCARE a Type II examination based on the Statement on Auditing Standards (SAS) No. 70, Service Organizations.

2.26.11 HIPAA Requirements

The CONTRACTOR shall require all its subcontractors to adhere to HIPAA requirements.

2.26.12 Compensation for Utilization Management Activities

Should the CONTRACTOR have a subcontract arrangement for utilization management activities, the CONTRACTOR shall ensure, consistent with 42 CFR 438.210(e) that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee, as provided by the Balanced Budget Act of 1997 and the provisions of 42 CFR 438.210(e).

2.26.13 Notice of Subcontractor Termination

2.26.13.1 When a subcontract that relates to the provision of services to enrollees or claims processing services is being terminated, the CONTRACTOR shall give at least thirty (30) calendar days prior written notice of the termination to TENNCARE and TDCI.

2.26.13.2 TENNCARE reserves the right to require this notice requirement and procedures for other subcontracts if determined necessary upon review of the subcontract for approval.

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2.27 COMPLIANCE WITH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

2.27.1 As a party to this Agreement, the CONTRACTOR hereby acknowledges its designation as a covered entity under the HIPAA regulations and agrees to comply with all applicable HIPAA regulations.

2.27.2 In accordance with HIPAA regulations, the CONTRACTOR shall, at a minimum:

2.27.2.1 Comply with requirements of the Health Insurance Portability and Accountability Act of 1996, including but not limited to the transactions and code set, privacy, security, and identifier regulations, by their designated compliance dates. Compliance includes meeting all required transaction formats and code sets with the specified data partner situations required under the regulations;

2.27.2.2 Transmit/receive from/to its providers, subcontractors, clearinghouses and TENNCARE all transactions and code sets required by the HIPAA regulations in the appropriate standard formats as specified under the law and as directed by TENNCARE so long as TENNCARE direction does not conflict with the law;

2.27.2.3 Agree that if it is not in compliance with all applicable standards defined within the transactions and code sets, privacy, security and all subsequent HIPAA standards, that it will be in breach of this Agreement and will then take all reasonable steps to cure the breach or end the violation as applicable. Since inability to meet the transactions and code sets requirements, as well as the privacy and security requirements can bring basic business practices between TENNCARE and the CONTRACTOR and between the CONTRACTOR and its providers and/or subcontractors to a halt, if for any reason the CONTRACTOR cannot meet the requirements of this Section, TENNCARE may terminate this Agreement in accordance with Section 5.2;

2.27.2.4 Ensure that Protected Health Information (PHI) data exchanged between the CONTRACTOR and TENNCARE is used only for the purposes of treatment, payment, or health care operations and health oversight and its related functions. All PHI data not transmitted for these purposes or for purposes allowed under the federal HIPAA regulations shall be de-identified to protect the individual enrollee's PHI under the privacy act;

2.27.2.5 Ensure that disclosures of PHI from the CONTRACTOR to TENNCARE shall be restricted as specified in the HIPAA regulations and will be permitted for the purposes of: treatment, payment, or health care operation; health oversight; obtaining premium bids for providing health coverage; or modifying, amending or terminating the group health plan. Disclosures to TENNCARE from the CONTRACTOR shall be as permitted and/or required under the law;

2.27.2.6 Report to TENNCARE within five (5) calendar days of becoming aware of any use or disclosure of PHI in violation of this Agreement by the CONTRACTOR, its officers, directors, employees, subcontractors or agents or by a third party to which the CONTRACTOR disclosed PHI;

2.27.2.7 Specify in its agreements with any agent or subcontractor that will have access to PHI that such agent or subcontractor agrees to be bound by the same restrictions, terms and conditions that apply to the CONTRACTOR pursuant to this Section 2.27;

2.27.2.8 Make available to TENNCARE enrollees the right to amend their PHI data in accordance with the federal HIPAA regulations. The CONTRACTOR shall also send information to enrollees educating them of their rights and necessary steps in this regard;

2.27.2.9 Make an enrollee's PHI data accessible to TENNCARE immediately upon request by TENNCARE;

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- 2.27.2.10 Make available to TENNCARE within ten (10) calendar days of notice by TENNCARE to the CONTRACTOR such information as in the CONTRACTOR's possession and is required for TENNCARE to make the accounting of disclosures required by 45 CFR 164.528. At a minimum, the CONTRACTOR shall provide TENNCARE with the following information:
 - 2.27.2.10.1 The date of disclosure;
 - 2.27.2.10.2 The name of the entity or person who received the HIPAA protected information, and if known, the address of such entity or person;
 - 2.27.2.10.3 A brief description of the PHI disclosed, and
 - 2.27.2.10.4 A brief statement of the purpose of such disclosure which includes an explanation of the basis for such disclosure.
- 2.27.2.11 In the event that the request for an accounting of disclosures is submitted directly to the CONTRACTOR, the CONTRACTOR shall within two (2) business days forward such request to TENNCARE. It shall be TENNCARE's responsibility to prepare and deliver any such accounting requested. Additionally, the CONTRACTOR shall institute an appropriate record keeping process and procedures and policies to enable the CONTRACTOR to comply with the requirements of this Section;
- 2.27.2.12 Make its internal policies and procedures, records and other documentation related to the use and disclosure of PHI available to the U.S. Secretary of Health and Human Services for the purposes of determining compliance with the HIPAA regulations upon request.
- 2.27.2.13 Create and adopt policies and procedures to periodically audit adherence to all HIPAA regulations, and for which CONTRACTOR acknowledges and promises to perform, including but not limited to, the following obligations and actions:
 - 2.27.2.13.1 Use administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI the CONTRACTOR creates, receives, maintains, or transmits on behalf of TENNCARE.
 - 2.27.2.13.2 Agree to ensure that any agent, including a subcontractor, to whom it provides PHI that was created, received, maintained, or transmitted on behalf of TENNCARE agrees to use reasonable and appropriate safeguards to protect the PHI.
 - 2.27.2.13.3 Agree to report to TENNCARE's privacy officer as soon as possible but within two (2) business days any unauthorized use or disclosure of enrollee PHI not otherwise permitted or required by HIPAA. Such immediate report shall include any security incident of which the CONTRACTOR becomes aware that represents unauthorized access to unencrypted computerized data and that materially compromises the security, confidentiality, or integrity of enrollee PHI maintained by the CONTRACTOR. The CONTRACTOR shall also notify TENNCARE's privacy officer within two (2) business days of any unauthorized acquisition of enrollee PHI by an employee or otherwise authorized user of the CONTRACTOR's system.
- 2.27.2.14 If feasible, return or destroy all PHI, in whatever form or medium (including any electronic medium) and all copies of an any data or compilations derived from and allowing identification of any individual who is a subject of that PHI upon termination, cancellation, expiration or other conclusion of the Agreement, and in accordance with Sections 2.21.6 and 2.25.6 of this Agreement. The CONTRACTOR shall complete such return or destruction as promptly as possible, but not later than thirty (30) days after the effective date of the termination, cancellation, expiration or other conclusion of the Agreement, including but not limited to, the provisions in Sections 2.21.6 and 2.25.6 of this Agreement. The CONTRACTOR shall identify any PHI that cannot feasibly be returned or destroyed. Within such thirty (30) days after the effective date of the termination, cancellation, expiration or other conclusion of the Agreement, including but not limited to, the provisions in Sections

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- 2.21.6 and 2.25.6 of this Agreement the CONTRACTOR shall: (1) certify on oath in writing that such return or destruction has been completed; (2) identify any PHI which can not feasibly be returned or destroyed; and (3) certify that it will only use or disclose such PHI for those purposes that make its return or destruction infeasible;
- 2.27.2.15 Implement all appropriate administrative, technical and physical safeguards to prevent the use or disclosure of PHI other than pursuant to the terms and conditions of this Agreement and, including but not limited to, confidentiality requirements in 45 CFR Parts 160 and 164;
- 2.27.2.16 Set up appropriate mechanisms to limit use or disclosure of PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure;
- 2.27.2.17 Create and implement policies and procedures to address present and future HIPAA regulation requirements as needed to include: use and disclosure of data; de-identification of data; minimum necessity access; accounting of disclosures; patients rights to amend, access, request restrictions; and right to file a complaint;
- 2.27.2.18 Provide an appropriate level of training to its staff and enrollees regarding HIPAA related policies, procedures, enrollee rights and penalties prior to the HIPAA implementation deadlines and at appropriate intervals thereafter;
- 2.27.2.19 Track training of CONTRACTOR staff and maintain signed acknowledgements by staff of the CONTRACTOR's HIPAA policies;
- 2.27.2.20 Be allowed to use and receive information from TENNCARE where necessary for the management and administration of this Agreement and to carry out business operations;
- 2.27.2.21 Be permitted to use and disclose PHI for the CONTRACTOR's own legal responsibilities;
- 2.27.2.22 Adopt the appropriate procedures and access safeguards to restrict and regulate access to and use by CONTRACTOR employees and other persons performing work for the CONTRACTOR to have only minimum necessary access to personally identifiable data within their organization;
- 2.27.2.23 Continue to protect personally identifiable information relating to individuals who are deceased;
- 2.27.2.24 Be responsible for informing its enrollees of their privacy rights in the manner specified under the regulations;
- 2.27.2.25 Make available PHI in accordance with 45 CFR 164.524;
- 2.27.2.26 Make available PHI for amendment and incorporate any amendments to protected health information in accordance with 45 CFR 164.526; and
- 2.27.2.27 Obtain a third (3rd) party certification of their HIPAA transaction compliance ninety (90) calendar days before the start date of operations.
- 2.27.3 The CONTRACTOR shall track all security incidents as defined by HIPAA, and, as required by Section 2.30.19, the CONTRACTOR shall periodically report in summary fashion such security incidents (see Section 2.30.19). The CONTRACTOR shall notify TENNCARE's privacy officer within two (2) business days of any security incident that would constitute a "breach of the security of the system" as defined in TCA 47-18-2107.

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- 2.27.4 TENNCARE and the CONTRACTOR are “information holders” as defined in TCA 47-18-2107. In the event of a breach of the security of CONTRACTOR’s information system, as defined by TCA 47-18-2107, the CONTRACTOR shall indemnify and hold TENNCARE harmless for expenses and/or damages related to the breach. Such obligations shall include but not be limited to mailing notifications to affected members. Substitute notice to written notice, as defined by TCA 47-18-2107(e)(2)and(3), shall only be permitted with TENNCARE’s express written approval.
- 2.27.5 In accordance with HIPAA regulations, TENNCARE shall, at a minimum, adhere to the following guidelines:
- 2.27.5.1 Make its individually identifiable health information available to enrollees for amendment and access as specified and restricted under the federal HIPAA regulations;
 - 2.27.5.2 Establish policies and procedures for minimum necessary access to individually identifiable health information with its staff regarding MCO administration and oversight;
 - 2.27.5.3 Adopt a mechanism for resolving any issues of non-compliance as required by law; and
 - 2.27.5.4 Establish similar HIPAA data partner agreements with its subcontractors and other business associates.

2.28 NON-DISCRIMINATION COMPLIANCE REQUIREMENTS

- 2.28.1 The CONTRACTOR shall comply with Section 5.21 of this Agreement regarding non-discrimination, proof of non-discrimination, and notices of non-discrimination.
- 2.28.2 In order to demonstrate compliance with federal and state regulations of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) the CONTRACTOR shall designate a staff person to be responsible for non-discrimination compliance as required in Section 2.29.1. This person shall provide instruction to all CONTRACTOR staff, providers and direct service subcontractors regarding the CONTRACTOR’s non-discrimination policies and procedures and all applicable non-discrimination compliance requirements of the TennCare program. The CONTRACTOR shall be able to show documented proof of such instruction.
- 2.28.3 The CONTRACTOR shall develop written policies and procedures for non-discrimination in the provision of services to persons with Limited English Proficiency as well as those that need assistance with communication in alternative formats. These policies and procedures shall be prior approved in writing by TENNCARE.
- 2.28.4 The CONTRACTOR shall, at a minimum, emphasize non-discrimination in its personnel policies and procedures as it relates to hiring, promoting, operational policies, contracting processes and participation on advisory/planning boards or committees.
- 2.28.5 The CONTRACTOR shall ask all staff to provide their race or ethnic origin and sex. The CONTRACTOR is required to request this information from all CONTRACTOR staff. CONTRACTOR staff response is voluntary. The CONTRACTOR is prohibited from utilizing information obtained pursuant to such a request as a basis for decisions regarding employment or in determination of compensation amounts.
- 2.28.6 The CONTRACTOR shall ask all providers for their race or ethnic origin. Provider response is voluntary. The CONTRACTOR is prohibited from utilizing information obtained pursuant to such a request as a basis for decision regarding participation in the CONTRACTOR’s provider network or in determination of compensation amounts.
- 2.28.7 The CONTRACTOR shall develop written policies and procedures for the investigation of complaints of discrimination. These policies and procedures shall be prior approved in writing by TENNCARE.

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- 2.28.8 The CONTRACTOR shall track and investigate all complaints alleging discrimination filed by employees (when the complaint is related to the TennCare program), enrollees, providers and subcontractors in which discrimination is alleged in the CONTRACTOR's TennCare MCO. The CONTRACTOR shall track, at a minimum, the following elements: identity of the party filing the complaint; the complainant's relationship to the CONTRACTOR; the circumstances of the complaint; date complaint filed; CONTRACTOR's resolution, if resolved; and name of CONTRACTOR staff person responsible for adjudication of the complaint.
- 2.28.9 The CONTRACTOR shall develop and have available a standardized complaint form to provide to a complainant upon request. This complaint form shall be in a format specified by TENNCARE.
- 2.28.10 The CONTRACTOR shall report on non-discrimination activities as described in Section 2.30.20.

2.29 PERSONNEL REQUIREMENTS

2.29.1 Staffing Requirements

- 2.29.1.1 The CONTRACTOR shall have sufficient staffing capable of fulfilling the requirements of this Agreement.
- 2.29.1.2 The CONTRACTOR shall submit to TENNCARE the names, resumes and contact information of the key staff identified below. In the event of a change to any of the key staff identified in Section 2.29.1.3, the CONTRACTOR shall notify TENNCARE within ten (10) business days of the change.
- 2.29.1.3 The minimum key staff requirements are listed below. If a full-time staff person is required, that means that one person shall perform that function (as opposed to multiple persons equaling a full-time equivalent). If a full-time staff person is not specified, the position does not require a full-time staff person;
 - 2.29.1.3.1 A full-time administrator/project director dedicated to the TennCare program who has clear authority over the general administration and day-to-day business activities of this Agreement;
 - 2.29.1.3.2 A full-time staff person dedicated to the TennCare program who will assist the CONTRACTOR in the transition from the CONTRACTOR's implementation team to regular ongoing operations. This person shall be onsite in Tennessee from the start date of this Agreement through at least one-hundred and twenty (120) days after the start date of operations.
 - 2.29.1.3.3 A full-time Medical Director dedicated to the TennCare program who is a licensed physician in the State of Tennessee to oversee and be responsible for all clinical activities, including but not limited to the proper provision of covered services to members, developing clinical practice standards and clinical policies and procedures;
 - 2.29.1.3.4 A full-time senior executive dedicated to the TennCare program who is a board certified psychiatrist in the State of Tennessee and has at least five (5) years combined experience in mental health and substance abuse services. This person shall oversee and be responsible for all behavioral health activities;
 - 2.29.1.3.5 A full-time chief financial officer dedicated to the TennCare program responsible for accounting and finance operations, including all audit activities;

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- 2.29.1.3.6 A full-time staff information systems director/manager dedicated to the TennCare program responsible for all CONTRACTOR information systems supporting this Agreement who is trained and experienced in information systems, data processing and data reporting as required to oversee all information systems functions supporting this Agreement including, but not limited to, establishing and maintaining connectivity with TennCare information systems and providing necessary and timely reports to TENNCARE;
- 2.29.1.3.7 A staff person designated as the contact available after hours for the “on-call” TennCare Solutions staff to contact with service issues;
- 2.29.1.3.8 A staff person to serve as the CONTRACTOR’s Non-discrimination Compliance Coordinator. This person shall be responsible for compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) on behalf of the CONTRACTOR. The CONTRACTOR shall report to TENNCARE in writing, to the attention of the Director of Non-Discrimination Compliance/Health Care Disparities, within ten (10) calendar days of the commencement of any period of time that the CONTRACTOR does not have a designated staff person for non-discrimination compliance. The CONTRACTOR shall report to TENNCARE at such time that the function is redirected as required in Section 2.29.1.2;
- 2.29.1.3.9 A full-time staff person dedicated to the TennCare program responsible for member services, who shall communicate with TENNCARE regarding member service activities;
- 2.29.1.3.10 A full-time staff person dedicated to the TennCare program responsible for provider services and provider relations, including all network management issues. This person shall be responsible for communicating with TENNCARE regarding provider service and provider relations activities;
- 2.29.1.3.11 A staff person responsible for all fraud and abuse detection activities, including the fraud and abuse compliance plan, as set forth in Section 2.20 of this Agreement;
- 2.29.1.3.12 A staff person responsible for all UM activities, including but not limited to overseeing prior authorizations. This person shall be a physician licensed in the State of Tennessee and shall ensure that UM staff have appropriate clinical backgrounds in order to make utilization management decisions;
- 2.29.1.3.13 A staff person responsible for all quality management activities. This person shall be a physician or registered nurse licensed in the State of Tennessee;
- 2.29.1.3.14 A staff person responsible for all appeal system resolution issues;
- 2.29.1.3.15 A staff person responsible for all claims management activities;
- 2.29.1.3.16 A staff person assigned to provide legal and technical assistance for and coordination with the legal system for court ordered services;
- 2.29.1.3.17 A staff person responsible for all MCO case management and care coordination issues, including but not limited to, disease management activities and coordination between physical and behavioral health services;
- 2.29.1.3.18 A consumer advocate for members receiving, or in need of, behavioral health services. This person shall be responsible for internal representation of members’ interests including but not limited to: ensuring input in policy development, planning, decision making, and oversight as well as coordination of recovery and resilience activities;
- 2.29.1.3.19 A staff person responsible for TENNderCare services;

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- 2.29.1.3.20 A staff person responsible for working with the Department of Children's Services;
- 2.29.1.3.21 A senior executive responsible for overseeing all subcontractor activities, if the subcontract is for the provision of covered benefits;
- 2.29.1.3.22 A staff person responsible for coordinating all activities and resolving issues related to CONTRACTOR/DBM coordination. This person shall be responsible for overseeing the work of the Care Coordination Committee and the Claims Coordination Committee as described in Section 2.9.8;
- 2.29.1.3.23 A staff person responsible for coordinating all activities and resolving issues related to CONTRACTOR/PBM coordination; and
- 2.29.1.3.24 A staff person designated for interfacing and coordinating with the TDMHDD Planning and Policy Council.
- 2.29.1.3.25 A specific staff person or persons designated as a liaison for the Department of Children's Services (DCS) which shall be identified, in writing, to TENNCARE and the DCS. The DCS liaison person(s) will be responsible for responsibilities described in Section 3.1.1 of this Agreement.
- 2.29.1.4 In addition to the key staff requirements described above, the CONTRACTOR shall have sufficient full-time clinical and support staff to conduct daily business in an orderly manner. This includes but is not limited to functions and services in the following areas: administration, accounting and finance, fraud and abuse, utilization management including prior authorizations, MCO case management and care coordination, quality management, member education and outreach, appeal system resolution, member services, provider services, provider relations, claims processing, and reporting.
- 2.29.1.5 The CONTRACTOR shall have a sufficient number of care coordinators and claims coordinators to conduct all required activities, including but not limited to collaboration with the DBM and coordination with various state agencies.
- 2.29.1.6 The CONTRACTOR shall appoint specific staff to an internal audit function as specified in Section 2.21.9.
- 2.29.1.7 The CONTRACTOR is not required to report to TENNCARE the names of staff not identified as key staff in Section 2.29.1.3. However, the CONTRACTOR shall provide its staffing plan to TENNCARE.
- 2.29.1.8 The CONTRACTOR's project director, transition staff person, Medical Director, psychiatrist, financial staff, member services staff, provider services staff, provider relations staff, UM staff, appeals staff, MCO case management staff, and TENNderCare staff person shall be located in the State of Tennessee. However, TENNCARE may authorize exceptions to this requirement. The CONTRACTOR shall seek TENNCARE's written prior approval to locate any of these staff outside of the State of Tennessee. The CONTRACTOR's request to locate required in-state staff to an out-of-state location shall include a justification of the request and an explanation of how services will be coordinated. If financial staff are not located in Tennessee the CONTRACTOR shall have the ability to issue a check within five (5) calendar days of a payment directive from TENNCARE.
- 2.29.1.9 The CONTRACTOR shall conduct training of staff in all departments to ensure appropriate functioning in all areas. This training shall be provided to all new staff members and on an ongoing basis for current staff.

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2.29.2 Licensure

The CONTRACTOR is responsible for ensuring that all persons, whether they are employees, agents, subcontractors, providers or anyone acting for or on behalf of the CONTRACTOR, are legally authorized to render services under applicable state law.

2.29.3 Board of Directors

The CONTRACTOR shall provide to TENNCARE, in writing, a list of all officers and members of the CONTRACTOR's Board of Directors. The CONTRACTOR shall notify TENNCARE, in writing, within ten (10) business days of any change thereto.

2.29.4 Employment and Contracting Restrictions

The CONTRACTOR shall not knowingly have a director, officer, partner, or person with beneficial ownership of more than five percent (5%) of the entity's equity who has been debarred or suspended by any federal agency. The CONTRACTOR may not have an employment, consulting, or any other agreement with a person that has been debarred or suspended by any federal agency for the provision of items or services that are significant and material to the entity's contractual obligation with the State. To the best of its knowledge and belief, the CONTRACTOR certifies by its signature to this Agreement that the CONTRACTOR and its principals:

- 2.29.4.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal or state department or contractor;
- 2.29.4.2 Have not within a three (3) year period preceding this Agreement been convicted of, or had a civil judgment rendered against them from commission of fraud, or a criminal offense in connection with obtaining attempting to obtain, or performing a public (federal, state, or local) transaction or grant under a public transaction, violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property;
- 2.29.4.3 Are not presently indicted for or otherwise criminally or civilly charged by a government entity (federal, state, or local) with commission of any of the offenses detailed in Section 2.29.4.2 of this Agreement; and
- 2.29.4.4 Have not within a three (3) year period preceding this Agreement had one or more public transactions (federal, state, or local) terminated for cause or default.

2.30 REPORTING REQUIREMENTS

2.30.1 General Requirements

- 2.30.1.1 The CONTRACTOR shall comply with all the reporting requirements established by TENNCARE. TENNCARE shall provide the CONTRACTOR with the appropriate reporting formats, instructions, submission timetables, and technical assistance as required. TENNCARE may, at its discretion, change the content, format or frequency of reports.
- 2.30.1.2 TENNCARE may, at its discretion, require the CONTRACTOR to submit additional reports both ad hoc and recurring. If TENNCARE requests any revisions to the reports already submitted, the CONTRACTOR shall make the changes and re-submit the reports, according to the time period and format required by TENNCARE.

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- 2.30.1.3 The CONTRACTOR shall submit all reports to TENNCARE, unless indicated otherwise in this Agreement, according to the schedule below:

DELIVERABLES	DUE DATE
Daily Reports	Within two (2) business days.
Weekly Reports	Wednesday of the following week.
Monthly Reports	20th of the following month.
Quarterly Reports	30th of the following month.
Semi-Annual Reports	January 31 and July 31.
Annual Reports	Ninety (90) calendar days after the end of the calendar year
On Request Reports	Within three (3) business days from the date of the request unless otherwise specified by TENNCARE.
Ad Hoc Reports	Within ten (10) business days from the date of the request unless otherwise specified by TENNCARE.

- 2.30.1.4 The CONTRACTOR shall submit all reports electronically and in the manner and format prescribed by TENNCARE. Except as otherwise specified by TENNCARE, all reports shall be specific to the Grand Region covered by this Agreement.
- 2.30.1.5 Except as otherwise provided in this Agreement, the CONTRACTOR shall submit all reports to the Bureau of TennCare.
- 2.30.1.6 The CONTRACTOR shall transmit to and receive from TENNCARE all transactions and code sets in the appropriate standard formats as specified under HIPAA and as directed by TENNCARE, so long as TENNCARE direction does not conflict with the law.

2.30.2 Eligibility, Enrollment and Disenrollment Reports

- 2.30.2.1 The CONTRACTOR shall comply with the requirements in Section 2.23.5 regarding eligibility and enrollment data exchange.
- 2.30.2.2 The CONTRACTOR shall submit a *Monthly Enrollment/Administrative Payment Reconciliation Report* that serves as a record that the CONTRACTOR has reconciled member eligibility data with administrative payments and verified that the CONTRACTOR has an enrollment record for all members for whom the CONTRACTOR has received an administrative payment.
- 2.30.2.3 The CONTRACTOR shall submit a *Quarterly Member Enrollment/Administrative Payment Report* in the event it has members for whom an administrative payment has not been made or an incorrect payment has been made. This report shall be submitted on a quarterly basis, with a one-month lag time and is due to TENNCARE by the end of the second month following the reporting period. For example, for the quarter ending September 30, the report is due by the end of November and should include all data received through the end of October for the quarter ending September 30. These quarterly reports shall include all un-reconciled items until such time that TENNCARE notifies the CONTRACTOR otherwise. The CONTRACTOR shall report this information in the formats provided in Attachment XIII, Exhibit A.

Amendment Number 20 (cont.)

- 2.30.2.4 TENNCARE may provide the CONTRACTOR with information on members for whom TENNCARE has been unable to locate or verify various types of pertinent information. Upon receipt of this information, the CONTRACTOR shall provide TENNCARE any information known by the CONTRACTOR that is missing or inaccurate in the report provided by TENNCARE. The CONTRACTOR shall submit this information to TENNCARE within the time frames specified by TENNCARE.
- 2.30.2.5 Until such time as an indicator for children in state custody and children transitioning out of state custody can be added to the daily eligibility updates received from TennCare, the CONTRACTOR shall reconcile enrollee eligibility data and administrative fee payments received from TennCare with an ad hoc report mutually agreed to by TennCare and the CONTRACTOR to facilitate timely identification of children in state custody or children transitioning out of state custody.
- 2.30.2.6 Pursuant to Section 2.4.6.2, the CONTRACTOR shall provide a listing of any enrollees for whom it has conflicting information to TennCare within ten (10) calendar days of the last day of each month.
- 2.30.2.7 The CONTRACTOR shall submit an *Immediate Eligibility Invoice* monthly in accordance with Attachment XIII, Exhibit N.
- 2.30.3 **LEFT BLANK INTENTIONALLY**
- 2.30.4 **Specialized Service Reports**
- 2.30.4.1 The CONTRACTOR shall submit a quarterly *Psychiatric Hospital/RTF Readmission Report* that provides: the percentage of members readmitted to the facility within seven (7) calendar days of discharge (the number of members readmitted divided by the total number of discharges); the percent of members readmitted within thirty (30) calendar days of discharge (the number of members readmitted divided by the total number of discharges); and an analysis of the findings with any actions or follow-up planned. The information shall be reported separately for members age eighteen (18) and over and under eighteen (18).
- 2.30.4.2 The CONTRACTOR shall submit a quarterly *Mental Health Case Management Report* that provides information on mental health case management appointments and refusals (see Section 2.6.5). The minimum data elements required are identified in Attachment XIII, Exhibit O.
- 2.30.4.3 The CONTRACTOR shall submit an annual *Supported Employment Report* that reports on the percent of SPMI adults receiving supported employment services that are gainfully employed in either part-time or full-time capacity for a continuous ninety (90) day period (defined as the number of adults receiving supported employment for a continuous ninety (90) day period divided by the number of SPMI adults receiving supported employment services during the year) and an analysis of the findings with any action or follow-up planned as a result of the findings.
- 2.30.4.4 The CONTRACTOR shall submit a quarterly *Behavioral Health Crisis Response Report* that provides information on behavioral health crisis services (see Section 2.6.5.8) including the data elements listed in Attachment XIII, Exhibit P. Specified data elements shall be reported separately for members ages eighteen (18) years and over and those under eighteen (18) years and all data elements shall be reported for each individual crisis service provider.
- 2.30.4.5 The CONTRACTOR shall submit a weekly *Member CRG/TPG Assessment Report* that contains information regarding the CRG assessments and TPG assessments (see Section 2.6.5.9) of members who have presented for mental health or substance abuse services or who have received CRG assessments and TPG assessments prior to obtaining such services. For purposes of this weekly *Member CRG/TPG Assessment Report*, the weekly report shall be due no later than 12:00 Noon, each Tuesday. The minimum data elements required are identified in Attachment XIII, Exhibit Q of this Agreement.

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- 2.30.4.6 On a quarterly basis the CONTRACTOR shall submit a *Rejected CRG/TPG Assessments Report* that provides, by agency, the number of rejected CRG/TPG assessments and the unduplicated number of and identifying information for the unapproved raters who completed the rejected assessments.
- 2.30.4.7 The CONTRACTOR shall submit an annual *CRG/TPG Assessments Audit Report*. The report shall contain the results of the CONTRACTOR's audits for the prior year of CRG/TPG assessments for accuracy and conformity to state policies and procedures.
- 2.30.4.8 The CONTRACTOR shall annually submit to TENNCARE its methodology for conducting the CRG/TPG assessment audits on March 1.
- 2.30.4.9 The CONTRACTOR shall submit a quarterly *Adverse Occurrences Report* that summarizes all adverse occurrences and their resolutions as reported to the CONTRACTOR by its providers.
- 2.30.4.10 The CONTRACTOR shall submit a quarterly *TENNCare Report*.

2.30.5 Disease Management Reports

- 2.30.5.1 The CONTRACTOR shall submit a quarterly *Disease Management Update Report* that includes, for each disease management program (see Section 2.8), a brief narrative description of the program, the total number of members in the program, the total number of members enrolled and disenrolled during the quarter, and a description of the specific provider and member interventions performed during the quarter.
- 2.30.5.2 The CONTRACTOR shall submit on July 1 an annual *Disease Management Report* that includes, for each disease management programs, a narrative description of the eligibility criteria and the method used to identify and enroll eligible members, the passive participation rate as defined by NCQA (the percentage of identified eligible members who have received an intervention divided by the total population who meet the criteria for eligibility), the total number of active members having one or more of the diagnosis codes (ICD-9 Codes) relating to each of the disease management programs, a description of stratification levels for each DM program including member criteria and associated interventions, a discussion of barriers and challenges to include resources, program structure, member involvement and provider participation, a summary of member satisfaction with the DM program, a written analysis of the data presented, a description of proposed changes to program, and information on the programs' activities, benchmarks and goals as described in Section 2.8.7.
- 2.30.5.3 The CONTRACTOR shall submit annually an updated *Disease Management Program Description* to include at a minimum the disease management components listed in Sections 2.8.1.4 through 2.8.1.5 of this Agreement.

2.30.6 Service Coordination Reports

- 2.30.6.1 MCO Case Management Reports
 - 2.30.6.1.1 The CONTRACTOR shall submit annually an updated *MCO Case Management Program Description* to TENNCARE describing the CONTRACTOR's MCO case management services. The report shall include a description of the criteria and process the CONTRACTOR uses to identify members for MCO case management, the process the CONTRACTOR uses to inform members and providers of the availability of MCO case management, a description of the MCO case management services provided by the CONTRACTOR and the methods used by the CONTRACTOR to evaluate its MCO case management program.
 - 2.30.6.1.2 The CONTRACTOR shall submit an annual *MCO Case Management Services Report* that addresses the activities in Section 2.9.4 of this Agreement by July 1 of each year.

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- 2.30.6.1.3 The CONTRACTOR shall submit a quarterly *MCO Case Management Update Report*. Enrollees who are enrolled in Disease Management need not be included in this report unless they are also receiving case management.
- 2.30.6.2 As necessary, the CONTRACTOR shall submit a listing of members identified as potential pharmacy lock-in candidates (see Section 2.9.7).
- 2.30.6.3 The CONTRACTOR shall submit a quarterly *Pharmacy Services Report* that includes a list of the providers and information on the interventions the CONTRACTOR has taken with the providers who appear to be operating outside industry or peer norms as defined by TENNCARE, have been identified as non-compliant as it relates to adherence to the PDL and/or generic prescribing patterns and/or are failing to follow required prior authorization processes and procedures the steps the CONTRACTOR has taken to personally contact each one as well as the outcome of these personal contacts.
- 2.30.6.4 The CONTRACTOR shall submit a *Pharmacy Services Report, On Request* when TENNCARE requires assistance in identifying and working with providers for any reason. These reports shall provide information on the activities the CONTRACTOR undertook to comply with TENNCARE's request for assistance, outcomes (if applicable) and shall be submitted in the format and within the time frame prescribed by TENNCARE.

2.30.7 Provider Network Reports

- 2.30.7.1 The CONTRACTOR shall submit a monthly *Provider Enrollment File* that includes information on all providers of TennCare health services, including physical and behavioral health providers (see Section 2.11). This includes but is not limited to, PCPs, physician specialists, hospitals, home health agencies, CMHAs, and emergency and non-emergency transportation providers. The report shall include contract providers as well as all non-contract providers with whom the CONTRACTOR has a relationship. The report shall be sorted by provider type. The CONTRACTOR shall submit this report by the 5th of each month, and upon TENNCARE request. Each monthly *Provider Enrollment File* shall include information on all providers of TennCare health services and shall provide a complete replacement for any previous *Provider Enrollment File* submission. Any changes in a provider's contract status from the previous submission shall be indicated in the file generated in the month the change became effective and shall be submitted in the next monthly file.
- 2.30.7.2 The CONTRACTOR shall submit an annual *Provider Compliance with Access Requirements Report* that summarizes the CONTRACTOR's monitoring activities, findings, and opportunities for improvement regarding provider compliance with applicable access standards. (See Section 2.11.1.10.)
- 2.30.7.3 The CONTRACTOR shall submit a quarterly *PCP Assignment Report* that provides the following information for non-dual members: Provider Name, Provider Medicaid I.D. Number, NPI Number, Number of Enrollees assigned by Enrollee Age Category. The enrollee age categories shall be consistent with the following: Age Under 1, Age 1 – 13, Age 14 – 20, Age 21- 44, Age 45 – 64, Age 65 +. This report shall be submitted using the format described by TennCare. (See Section 2.11.2.)
- 2.30.7.4 The CONTRACTOR shall submit an annual *Report of Essential Hospital Services* by September 1 of each year. The CONTRACTOR shall use the format in Attachment XIII, Exhibit G.
- 2.30.7.5 The CONTRACTOR shall submit a quarterly *Behavioral Health Initial Appointment Timeliness Report* that shall include the average time between the intake assessment appointment and the member's next scheduled appointment or admission. The report shall provide this information by type of service and shall include an analysis of the findings and any actions or follow-up planned as a result of the findings.

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- 2.30.7.6 The CONTRACTOR shall submit an annual *FQHC Report* by January 1 of each year. The CONTRACTOR shall use the form provided in Attachment XIII, Exhibit.
- 2.30.7.7 The CONTRACTOR shall submit a monthly *Institutions for Mental Diseases (IMD) Out-of-State Report* on the use of IMDs utilized outside of the State of Tennessee. The report shall be submitted by the 5th of each month for the previous month.

2.30.8 Provider Agreement Report

The CONTRACTOR shall submit a monthly *Single Case Agreements Report* using the format as described by TennCare. (See Section 2.12.4.)

2.30.9 Provider Payment Reports

- 2.30.9.1 The CONTRACTOR shall submit a quarterly *Related Provider Payment Report* that lists all related providers and subcontractors to whom the CONTRACTOR has made payments during the previous quarter and the payment amounts. (See Section 2.13.15.).
- 2.30.9.2 The CONTRACTOR shall submit a weekly *Invoice* to notify the State of the amount to be paid to providers at least 72 hours in advance of distribution of provider checks.
- 2.30.9.3 The CONTRACTOR shall submit a *Check Register Report* with the weekly Invoice to support the payments released to providers.
- 2.30.9.4 The CONTRACTOR shall submit a *Claims Data Extract* within seven (7) calendar days after the CONTRACTOR's request of the funds which shall be generated from the managed care claims processing system supporting the release of provider payments. (See Section 2.13.8)
- 2.30.9.5 The CONTRACTOR shall submit a *Reconciliation Report* seven (7) days of the claims data extract for the total paid amounts between the funds released for payment to providers, the supporting claims data extract, and the encounter data submissions for the relevant adjudication cycle.
- 2.30.9.6 If the CONTRACTOR does not automatically credit TennCare for receivables within ninety (90) calendar days, the CONTRACTOR shall submit a *Provider Payment Issue Report* and shall determine the extent of the collection effort required based on the table below. This table identifies the minimum collection threshold for cumulative receivable balances. All collection efforts shall be clearly documented.

Receivable Balance	Collection Attempts		Forwarded to Collections
	45 Day	90 Day	
< \$10	None Required		
\$10 - \$49.99	✓		
\$50 - \$99.99	✓	✓	
\$100 - Over	✓	✓	✓
Responsibility	MCC		TENNCARE

- 2.30.9.6.1 The first notice shall occur by day forty-five (45) and may be in the form of notice in a remittance advice or a demand memo; however, the ninety (90) day notice must be made using a demand memo. Each of these notices shall be sent within five (5) business days of becoming due.
- 2.30.9.6.2 Additional collection attempts by the CONTRACTOR are not necessary if a collection notice is returned because the provider has gone out-of-business or has declared bankruptcy for the period the receivable was established. This circumstance must be reported in the "Uncollectible Accounts Report" as described below.

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- 2.30.9.7 If the CONTRACTOR does not automatically credit TENNCARE for aged accounts within sixty (60) calendar days, the CONTRACTOR shall submit to TENNCARE, within ten (10) business days following the end of the month, an *Aged Accounts Receivable Report*. The effective date of this report shall be the last Friday of the previous month. The report shall have an easily identifiable date, contain a total report balance, and provide <30, 30, 60, 90, and >120 calendar day balances. Although only totals are required, the CONTRACTOR may report aging balances at the account level. If the CONTRACTOR is not reporting at the account level, the CONTRACTOR shall have the capability to identify the detail that makes up a total if necessary.
- 2.30.9.8 If the CONTRACTOR does not automatically credit TENNCARE for uncollectible accounts within ninety (90) calendar days, the CONTRACTOR shall submit to TENNCARE, within ten (10) business days following the end of the month, an *Uncollectible Accounts Report*, in a format described by TENNCARE, for accounts meeting the following criteria:
- 2.30.9.8.1 the account proves to be uncollectible after 120 calendar days, or
- 2.30.9.8.2 the provider account owner has gone out-of-business, or
- 2.30.9.8.3 the provider account owner has declared bankruptcy.
- 2.30.9.9 In addition to the *Uncollectible Accounts Report*, the CONTRACTOR shall submit scanned copies of returned envelopes or legal documents referencing providers that have gone out-of-business and/or declared bankruptcy.
- 2.30.9.10 The Contractor shall submit a monthly *Outstanding Checks Report* detailing all checks remitted to providers, enrollees or vendors on behalf of the State which remain outstanding (which have not been cashed) greater than one hundred eighty (180) calendar days. Reports are due within fifteen (15) business days after the end of the month.

2.30.10 Utilization Management Reports

- 2.30.10.1 The CONTRACTOR shall annually submit, by July 30th of each year, a UM program description and an associated work plan and evaluation. These documents must be prior approved by the CONTRACTOR's oversight committee prior to submission to TENNCARE. The annual evaluation shall include an analysis of findings and actions taken.
- 2.30.10.2 The CONTRACTOR shall submit quarterly *Cost and Utilization Reports*. These reports shall be in an Excel spreadsheet format and submitted with a ninety (90) day lag and shall be due to TENNCARE one hundred five (105) calendar days following the quarter for which the CONTRACTOR is reporting. These reports shall be submitted on both a cumulative year basis and on a rolling twelve (12) month basis.
- 2.30.10.3 The CONTRACTOR shall provide quarterly *Cost and Utilization Summaries*. These summaries shall report on services paid during the previous quarter. The summaries shall include all data elements as required by TennCare. The CONTRACTOR shall provide the reports separately for the following populations: Groups 1A and 1B, Group 2, and Groups 3 through 6.
- 2.30.10.4 The CONTRACTOR shall identify and report the number of members who incurred claims in excess of twenty-five thousand dollars (\$25,000) on a rolling quarterly basis (high-cost claimants). The CONTRACTOR shall report the member's age, sex, primary diagnosis, and amount paid by claim type for each member. The name, and other identifying information of the member shall be blinded in order to maintain confidentiality.
- 2.30.10.5 The CONTRACTOR shall submit quarterly *Prior Authorization Reports* that include information by service and separately for adults and children, on the number of requests received, number processed, number approved, number denied, and denial reason.

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- 2.30.10.6 The CONTRACTOR shall submit a copy of the *Referral Provider Listing* (see Section 2.14.3.5), a data file of the provider information used to create the listing, and documentation from the CONTRACTOR's mail room or outside vendor indicating the quantity of the referral provider listings mailed to providers, the date mailed, and to whom. The CONTRACTOR shall submit this information at the same time it is sent to the providers as required in Section 2.14.3.5.
- 2.30.10.8 The CONTRACTOR shall submit a semi-annual *Emergency Department Threshold Report* to TENNCARE no later than February 28th and August 31st each year identifying interventions initiated for members who exceeded the defined threshold for ED usage.

2.30.11 Quality Management/Quality Improvement Reports

- 2.30.11.1 The CONTRACTOR shall annually submit, by July 30, an approved (by the CONTRACTOR's QM/QI Committee) QM/QI Program Description, Associated Work Plan, and Annual Evaluation.
- 2.30.11.2 The CONTRACTOR shall submit an annual *Report on Performance Improvement Projects* that includes the information specified in Section 2.15.3. The report shall be submitted annually on July 30.
- 2.30.11.3 The CONTRACTOR shall submit an annual *Report of Performance Indicator Results, Audited CAHPS Results and Audited HEDIS Results* by June 15 of each year (see Sections 2.15.4, 2.15.6 and 2.15.7).
- 2.30.11.4 The CONTRACTOR shall submit its *NCQA Accreditation Report* (the final bound copy from NCQA) immediately upon receipt, but not to exceed ten (10) calendar days from notification by NCQA.
- 2.30.11.5 The CONTRACTOR shall submit its annual reevaluation of accreditation status based on HEDIS scores immediately upon receipt, but not to exceed ten (10) calendar days from notification by NCQA.

2.30.12 Customer Service Reports/Provider Service Reports

- 2.30.12.1 Member Services/UM/ED Phone Line Reports
 - 2.30.12.1.1 The CONTRACTOR shall submit a quarterly *Member Services and UM Phone Line Report*. The data in the report shall be recorded by month and shall include the detailed rate calculations. The CONTRACTOR shall submit the report as described by TennCare.
 - 2.30.12.1.2 The CONTRACTOR shall submit a quarterly *24/7 Nurse Triage Line Report* that lists the total calls received by the 24/7 nurse triage line including the ultimate disposition of the call (e.g. education only, no referral for care; referred to primary care provider for care, referred to emergency department for care). If the CONTRACTOR uses the 24/7 nurse line to fulfill the requirements set forth in Section 2.18.4.7 of this Agreement, such calls shall be separately delineated in the report in accordance with the requirements described in Section 2.30.12.1.3 of this Agreement.
 - 2.30.12.1.3 The CONTRACTOR shall submit a quarterly *ED Assistance Tracking Report* that provides the total number of calls received pertaining to patients in EDs needing assistance in accessing care in an alternative setting. Such report shall include the date and time of the call, identifying information for the member, the name and location of the hospital, the ultimate response to the call (e.g. appointment made with PCP) and the elapsed time from ED visit until appointment in alternative setting. If the CONTRACTOR uses the nurse triage line to provide appointment assistance to non-emergency ED patients, the aforementioned information may be provided in conjunction with the report discussed at Section 2.30.12.1.2.

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- 2.30.12.2 The CONTRACTOR shall report separately any member services or utilization management phone lines operated by subcontractors.
- 2.30.12.3 The CONTRACTOR shall submit a quarterly *Translation/Interpretation Services Report*. The report shall list each request and include the name and member identification number for each member to whom translation/interpretation service was provided, the date of the request, the date provided, and the identification of the translator/interpreter.
- 2.30.12.4 The CONTRACTOR shall submit an annual *Provider Satisfaction Survey Report* that summarizes the provider survey methods and findings and provides analysis of opportunities for improvement (see Section 2.18.7.3).
- 2.30.12.5 The CONTRACTOR shall submit a quarterly *Provider Complaints Report* that provides information on the number and type of provider complaints received, either in writing or by phone. The data shall be reported by month.

2.30.13 Fraud and Abuse Reports

- 2.30.13.1 The CONTRACTOR shall submit an annual *Fraud and Abuse Activities Report*. This report shall summarize the results of its fraud and abuse compliance plan (see Section 2.20) and other fraud and abuse prevention, detection, reporting, and investigation measures, and should cover results for the fiscal year ending June 30. The report shall be submitted by September 30 of each year in the format reviewed and approved by TENNCARE (as part of the CONTRACTOR's compliance plan).
- 2.30.13.2 The CONTRACTOR shall submit an annual fraud and abuse compliance plan (see Section 2.20.3 of this Agreement).
- 2.30.13.3 On an annual basis the CONTRACTOR shall submit its policies for employees, contractors, and agents that comply with Section 1902(a)(68) of the Social Security Act. These policies shall be submitted by July 1 of each year.

2.30.14 Financial Management Reports

2.30.14.1 Third Party Liability (TPL) Resources Reports

- 2.30.14.1.1 The CONTRACTOR shall submit a monthly, quarterly and annual *Recovery and Cost Avoidance Report* that includes any recoveries for third party resources as well as funds for which the CONTRACTOR does not pay a claim due to TPL coverage or Medicare coverage. This CONTRACTOR shall calculate cost savings in categories described by TENNCARE.
- 2.30.14.1.2 The CONTRACTOR shall submit an *Other Insurance Report* that provides information on any members who have other insurance. This report shall be submitted in a format and frequency described by TENNCARE.

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2.30.14.2 Financial Reports to TENNCARE

2.30.14.2.1 For the purpose of monitoring actual medical expenses, TennCare shall establish a Medical Fund Target by eligibility grouping for TennCare Select. The CONTRACTOR shall submit a monthly *Medical Fund Target Report* with cumulative year to date calculation using the format described by TennCare. The CONTRACTOR shall report all medical expenses and complete the supporting claims lag tables. This report shall be accompanied by a letter from an actuary, who may be an employee of the CONTRACTOR, indicating that the reports, including the estimate for incurred but not reported expenses, has been reviewed for accuracy. The CONTRACTOR shall also file this report with its NAIC filings due in March and September of each year using an accrual basis that includes incurred but not reported amounts by calendar service period that have been certified by an actuary. This report shall reconcile to NAIC filings including the supplemental TennCare income statement. The CONTRACTOR shall also reconcile the amount paid reported on the supporting claims lag tables to the amount paid for the corresponding period as reported on the CONTRACTOR's encounter file submission as specified in Sections 2.30.16.3 and 2.23.4.

2.30.14.2.2 The CONTRACTOR shall submit an annual *Ownership and Financial Disclosure Report* to TENNCARE. This report shall include full and complete information regarding ownership, financial transactions and persons as described in Section 2.21.8 and shall be submitted March 1 of each calendar year and at other times as required by TENNCARE.

2.30.14.2.3 The CONTRACTOR shall submit its annual audit plan on March 1 of each year (see Section 2.21.9).

2.30.14.3 TDCI Financial Reports

2.30.14.3.1 By no later than December 31 of each year, the CONTRACTOR shall submit to TDCI an annual *Financial Plan and Projection of Operating Results Report*. This submission shall include the CONTRACTOR's budget projecting revenues earned and expenses incurred on a calendar year basis through the term of this Agreement. This budget shall be prepared in accordance with the form prescribed by TDCI and shall include narratives explaining the assumptions and calculations utilized in the projections of operating results.

2.30.14.3.2 By no later than July 31 of each year, the CONTRACTOR shall submit to TDCI a mid-year *Comparison of Actual Revenues and Expenses to Budgeted Amounts Report*. If necessary, the CONTRACTOR shall revise the calendar year budget based on its actual results of operations. Any revisions to the budget shall include narratives explaining the assumptions and calculations utilized in making the revisions.

2.30.14.3.3 The CONTRACTOR shall submit to TDCI an *Annual Financial Report* required to be filed by all licensed health maintenance organizations pursuant to TCA 56-32-108. This report shall be on the form prescribed by the National Association of Insurance Commissioners (NAIC) for health maintenance organizations and shall be submitted to TDCI on or before March 1 of each calendar year. It shall contain an income statement detailing the CONTRACTOR's fourth quarter and year-to-date revenues earned and expenses incurred as a result of the CONTRACTOR's participation in the TennCare program. The CONTRACTOR in preparing this annual report shall comply with any and all rules and regulations of TDCI related to the preparation and filing of this report. This Annual Report shall also be accompanied by the Medical Loss Ratio report, where applicable, completed on a calendar year basis. The CONTRACTOR shall submit a reconciliation of the Medical Loss Ratio report to the annual NAIC filing using an accrual basis that includes an actuarial certification of the claims payable (reported and unreported).

2.30.14.3.4 The CONTRACTOR shall file with TDCI, a *Quarterly Financial Report*. These reports shall be on the form prescribed by the National Association of Insurance Commissioners for health maintenance organizations and shall be submitted to TDCI on or before May 15 (covering first quarter of current year), August 15 (covering second quarter of current year) and November 1 (covering third quarter of current year). Each quarterly report shall also contain

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an income statement detailing the CONTRACTOR's quarterly and year-to-date revenues earned and expenses incurred as a result of the CONTRACTOR's participation in the TennCare program. The second quarterly report (submitted on September 1) shall include the Medical Loss Ratio report completed on an accrual basis that includes an actuarial certification of the claims payable (reported and unreported) and, if any, other actuarial liabilities reported. The actuarial certification shall be prepared in accordance with National Association of Insurance Commissioners guidelines. The CONTRACTOR shall also submit a reconciliation of the Medical Loss Ratio report to the second quarterly NAIC report.

2.30.14.3.5 The CONTRACTOR shall submit to TDCI annual *Audited Financial Statements*. Such audit shall be performed in accordance with NAIC Annual Statement Instructions regarding the annual audited financial statements. There are three (3) exceptions to the NAIC statement instructions:

2.30.14.3.5.1 The CONTRACTOR shall submit the audited financial statements covering the previous calendar year by May 1 of each calendar year.

2.30.14.3.5.2 Any requests for extension of the May 1 submission date must be granted by the Office of the Comptroller of the Treasury pursuant to the "Contract to Audit Accounts."

2.30.14.3.5.3 The report shall include an income statement addressing the TENNCARE operations of the CONTRACTOR.

2.30.15 Claims Management Reports

2.30.15.1 The CONTRACTOR shall submit a monthly *Claims Payment Accuracy Report*. The report shall include the results of the internal audit of the random sample of all "processed or paid" claims (described in Section 2.22.6) and shall report on the number and percent of claims that are paid accurately. As provided in Section 2.22.6.6, if the CONTRACTOR subcontracts for the provision of any covered services, and the subcontractor is responsible for processing claims, then the CONTRACTOR shall submit a claims payment accuracy percentage report for the claims processed by the subcontractor. The report for each subcontractor shall include the results of the internal audit conducted in compliance with Section 2.22.6 and shall report on the number and percent of claims that are paid accurately.

2.30.15.2 The CONTRACTOR shall submit a quarterly *Explanation of Benefits (EOB) Report*. This report shall summarize the number of EOBs sent by category, member complaints, and complaint resolution (including referral to TBI/OIG). (See Section 2.22.8.)

2.30.15.3 The CONTRACTOR shall submit a weekly *Claims Activity Report*. This report shall identify the number of claims received, number of claims denied (by reason), number of claims paid, and total amount paid by the categories of service specified by TENNCARE.

2.30.16 Information Systems Reports

2.30.16.1 The CONTRACTOR shall submit an annual *Systems Refresh Plan* on December 1 for the upcoming year that meets the requirements in Section 2.23.1.6.

2.30.16.2 The CONTRACTOR shall submit *Encounter Data Files* in a standardized format as specified by TENNCARE (see Section 2.23.4) and transmitted electronically to TENNCARE on a weekly basis.

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- 2.30.16.3 The CONTRACTOR shall provide an electronic version of a reconciliation between the amount paid as captured on the CONTRACTOR's encounter file submissions and the amount paid as reported by the CONTRACTOR in the 'CMS 1450 Claims Triangle' and 'CMS 1500 Claims Triangle' that accompanies the monthly Medical Loss Ratio report (see Section 2.30.14.2.1). In the event of any variances, the CONTRACTOR shall submit a written explanation accompanied by a 'CMS 1450 Claims Triangle' by category of service and a 'CMS 1500 Claims Triangle' by category of service, as applicable, to substantiate the explanation of the variance and identify the categories of services to which the variance is attributable. In the event that TENNCARE requires further detail of the variances listed, the CONTRACTOR shall provide any other data as requested by TENNCARE. This information shall be submitted with the Medical Fund Target report.
- 2.30.16.4 The CONTRACTOR shall provide any information and/or data requested in a format to be specified by TENNCARE as required to support the validation, testing or auditing of the completeness and accuracy of encounter data submitted by the CONTRACTOR.
- 2.30.16.5 The CONTRACTOR shall submit a monthly *Systems Availability and Performance Report* that provides information on availability and unavailability by major system as well as response times for the CONTRACTOR's Confirmation of MCO Enrollment and Electronic Claims Management functions, as measured within the CONTRACTOR's span of control.
- 2.30.16.6 The CONTRACTOR shall submit a baseline *Business Continuity and Disaster Recovery (BC-DR)* plan for review and written approval as specified by TENNCARE. The CONTRACTOR shall communicate proposed modifications to the BC-DR plan at least fifteen (15) calendar days prior to their proposed incorporation. Such modifications shall be subject to review and written approval by TENNCARE.

2.30.17 Administrative Requirements Reports

The CONTRACTOR shall submit a semi-annual *Report on the Activities of the CONTRACTOR's Behavioral Health Advisory Committee* regarding the activities of the behavioral health advisory committee established pursuant to Section 2.24.2. These reports shall be submitted to TENNCARE on March 1 and September 1 of each year.

2.30.18 Subcontract Reports

- 2.30.18.1 If the CONTRACTOR has subcontracted claims processing for TennCare claims, the CONTRACTOR shall provide to TENNCARE a Type II examination based on the Statement on Auditing Standards (SAS) No. 70, Service Organizations for each non-affiliated organization processing claims that represent more than twenty percent (20%) of TennCare medical expenses of the CONTRACTOR. This report shall be performed by an independent auditor ("service auditor") and shall be due annually on May 1 for the preceding year operations or portion thereof.
- 2.30.18.2 In a Type II report, the service auditor will express an opinion on (1) whether the service organization's description of its controls presents fairly, in all material respects, the relevant aspects of the service organization's controls that had been placed in operation as of a specific date, and (2) whether the controls were suitably designed to achieve specified control objectives, and (3) whether the controls that were tested were operating with sufficient effectiveness to provide reasonable, but not absolute, assurance that the control objectives were achieved during the period specified. The audit of control activities over information and technology related processes related to TennCare claims processing by the subcontractor should include the following:

2.30.18.2.1 *General Controls*

2.30.18.2.1.1 Personnel Policies

2.30.18.2.1.2 Segregation of Duties

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- 2.30.18.2.1.3 Physical Access Controls
- 2.30.18.2.1.4 Hardware and System Software
- 2.30.18.2.1.5 Applications System Development and Modifications
- 2.30.18.2.1.6 Computer Operations
- 2.30.18.2.1.7 Data Access Controls
- 2.30.18.2.1.8 Contingency and Business Recovery Planning
- 2.30.18.2.2 *Application Controls*
 - 2.30.18.2.2.1 Input
 - 2.30.18.2.2.2 Processing
 - 2.30.18.2.2.3 Output
 - 2.30.18.2.2.4 Documentation Controls

2.30.19 **HIPAA Reports**

The CONTRACTOR shall submit a Privacy/Security Incident Report. This report shall be provided at least annually, but the CONTRACTOR shall provide the report more frequently if requested by TENNCARE. The report shall include, at a minimum, the date of the incident, the date of notification to TENNCARE's privacy officer, the nature and scope of the incident, the CONTRACTOR's response to the incident, and the mitigating measures taken by the CONTRACTOR to prevent similar incidents in the future. "Port scans" or other unsuccessful queries to the CONTRACTOR's information system shall not be considered a privacy/security incident for purposes of this report.

2.30.20 **Non-Discrimination Compliance Reports**

- 2.30.20.1 The CONTRACTOR shall submit an annual *Summary Listing of Servicing Providers* that includes race or ethnic origin of each provider. The listing shall include, at a minimum, provider name, address, race or ethnic origin and shall be sorted by provider type (e.g., pediatrician, surgeon, etc.). The CONTRACTOR shall use the following race or ethnic origin categories: American Indian or Alaskan Native, Asian or Pacific Islander, Hispanic origin and other race/ethnic origin as indicated by TENNCARE.
- 2.30.20.2 The CONTRACTOR shall submit a quarterly *Supervisory Personnel Report* that contains a summary listing totaling the number of supervisory personnel by race or ethnic origin and sex. This report shall provide the number of male supervisors who are White, Black (not of Hispanic origin), American Indian or Alaskan Native, Asian or Pacific Islander, Hispanic origin and other race/ethnicity as indicated by TENNCARE and number of female supervisors who are White, Black (not of Hispanic origin), American Indian or Alaskan Native, Asian or Pacific Islander, Hispanic origin and other race/ethnic origin females as indicated by TENNCARE.
- 2.30.20.3 The CONTRACTOR shall submit a quarterly *Alleged Discrimination Report*. The report shall include a listing of all complaints alleging discrimination filed by employees, members, providers and subcontractors in which discrimination is alleged by the CONTRACTOR's MCO. Such listing shall include, at a minimum, the identity of the party filing the complaint, the complainant's relationship to the CONTRACTOR, the circumstances of the complaint, date complaint filed, the CONTRACTOR's resolution, if resolved, and the name of the CONTRACTOR staff person responsible for adjudication of the complaint.

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- 2.30.20.4 On an annual basis the CONTRACTOR shall submit a copy of the CONTRACTOR's non-discrimination policy that demonstrates non-discrimination in provision of services to members with Limited English Proficiency. This shall include a report that lists all interpreter/translator services used by the CONTRACTOR in providing services to members with Limited English Proficiency or that need communication assistance in an alternative format. The listing shall identify the provider by full name, address, phone number, and hours services are available.
- 2.30.20.5 The CONTRACTOR shall annually submit its *Non-Discrimination Compliance Plan and Assurance of Non-Discrimination* to TENNCARE. The signature date of the CONTRACTOR's Title VI Compliance Plan shall coordinate with the signature date of the CONTRACTOR's Assurance of Non-Discrimination.

2.30.21 Terms and Conditions Reports

- 2.30.21.1 Quarterly, by January 30, April 30, July 30, and October 30 each year the CONTRACTOR shall make written disclosure regarding conflict of interest that includes the elements in Section 5.7.
- 2.30.21.2 Pursuant to Section 5.30, on a semi-annual basis the CONTRACTOR shall submit the attestation in Attachment II.
- 2.30.21.3 The CONTRACTOR shall maintain documentation that demonstrates the cost effectiveness of any non-covered services that are provided to TennCare enrollees and for which the CONTRACTOR seeks reimbursement from the state. A report summarizing all such documentation for the preceding year shall be submitted by the CONTRACTOR no later than sixty (60) calendar days after the end of each state fiscal year.

11. Section 5 shall be deleted and replaced with a new Section 4 subsequent sections shall be renumbered, including any references thereto. The new Section 4 shall read as follows:

4 PAYMENT TERMS AND CONDITIONS

4.1 Administrative Fee

- 4.1.1 The CONTRACTOR shall be paid a fixed fee per member per month for the administration of TennCare Select according to the requirements of this Agreement. The administrative fee to be paid shall be described in Attachment XVI of this Agreement.
- 4.1.2 TennCare or its appointed agent shall make payment by the fifth working day of each month to the CONTRACTOR for the CONTRACTOR's satisfactory performance of its duties and responsibilities as set forth in this Agreement. Each month payment to the CONTRACTOR shall be equal to the number of enrollees certified by TENNCARE multiplied by the administrative fee for the appropriate enrollee category. The actual amount owed the CONTRACTOR for each enrollee shall be determined by dividing the appropriate monthly administrative fee by the number of days in the month and then multiplying the quotient of this transaction by the actual number of days the enrollee was enrolled in the plan.
- 4.1.3 Payment for enrollees shall start the effective date of the enrollee's enrollment in the plan.
- 4.1.4 The CONTRACTOR agrees the State may retroactively recoup Administrative Fee payments for deceased enrollees. Retroactive recoupment will be deducted from the monthly payment for the following month. Payments may be recouped back to the date of death. This is the only provision whereby the State may retroactively recoup administrative fee payments from the CONTRACTOR for enrollees retroactively terminated from TennCare Select.
- 4.1.5 Administrative fee payments made in accordance with Section 4.1.1, 4.1.2, and Attachment XVI will not include payment for children in state custody for whom Immediate Eligibility was established and who were not subsequently found to be TennCare eligible. TennCare shall make a separate payment for said children upon receipt of an invoice from the CONTRACTOR. The

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invoice shall be submitted to TENNCARE in the form and format specified in Attachment XIII, Exhibit N on a monthly basis. The administrative fee due shall be equal to the number of enrollees for whom Immediate Eligibility was established multiplied by a flat rate equal to the per member per month for Group 1.A, for the full 45 day eligibility period.

4.2 PAY-FOR-PERFORMANCE QUALITY INCENTIVE PAYMENTS

4.2.1 General

4.2.1.1 TENNCARE will make incentive payments to the CONTRACTOR in accordance with this Section 4.2.

4.2.1.2 The TennCare Select HEDIS score for the previous calendar year for each of the measures specified in Sections 4.2.2 and 4.2.3 will serve as the baseline rate in the NCQA minimum effect size change calculations (see Section 4.2.4 below).

4.2.2 Physical Health HEDIS Measures

4.2.2.1 Beginning on July 1, 2010, on July 1 of each year, the CONTRACTOR will be eligible for a \$.03 PMPM payment, applied to member months from the preceding calendar year, for each of the audited HEDIS measures specified in Section 4.2.2.2 below for which significant improvement has been demonstrated. Significant improvement is defined using NCQA's minimum effect size change methodology (see Section 4.2.4 below).

4.2.2.2 Incentive payments will be available for the following audited HEDIS measures:

4.2.2.2.1 Appropriate Treatment for Children with Upper Respiratory Infection (URI);

4.2.2.2.2 Childhood Immunization Status - MMR;

4.2.2.2.3 Children and Adolescents' Access to PCP – 7-11 year old age group;

4.2.2.2.4 Children and Adolescents' Access to PCP – 12-19 year old age group;

4.2.2.2.5 Well Child Visits – 3rd, 4th, 5th and 6th years of life; and

4.2.2.2.6 Adolescent Well Care Visits.

4.2.3 Behavioral Health HEDIS Measures

4.2.3.1 On July 1 of 2011, the CONTRACTOR will be eligible for a \$.03 PMPM payment, applied to member months from the preceding calendar year, for each of the following audited HEDIS measures for which the CONTRACTOR scores at or above the 75th national Medicaid percentile, as calculated by NCQA.

4.2.3.1.1 Follow-up After Hospitalization for Mental Illness; and

4.2.3.1.2 Follow-up Care for Children Prescribed ADHD Medication.

4.2.3.2 Beginning on July 1, 2012, on July 1 of each year, the CONTRACTOR will be eligible for a \$.03 PMPM payment, applied to member months from the preceding calendar year, for each of the audited HEDIS measures specified in Section 4.2.3 below (calculated from the preceding calendar year's data) for which significant improvement has been demonstrated. Significant improvement is defined using NCQA's minimum effect size change methodology (see Section 4.2.4 below).

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4.2.3.2.1 Follow-up After Hospitalization for Mental Illness; and

4.2.3.2.2 Follow-up Care for Children Prescribed ADHD Medication.

4.2.4 NCQA Minimum Effect Size Change Methodology

The NCQA minimum effect size change methodology is as follows:

Baseline Rate	Minimum Effect Size
0-59	At least a 6 percentage point change
60-74	At least a 5 percentage point change
75-84	At least a 4 percentage point change
85-92	At least a 3 percentage point change
93-96	At least a 2 percentage point change
97-99	At least a 1 percentage point change

4.3 Shared Risk Terms and Conditions

4.3.1 Populations

Effective March 1, 2009, the terms of the CONTRACTOR’s shared risk responsibility shall be described below. The shared risk terms shall apply to the following populations as described in Section 2.4 of this Agreement: Group 1.A, Group 1.B, and Group 2.

4.3.2 Components

The CONTRACTOR will be paid an administrative fee to administer the TennCare MCO benefits. Additionally, there will be both an upside potential (bonus) as well as downside potential (risk). Bonus and the risk will be based on the following components as described below:

4.3.2.1 EPSDT, and

4.3.2.2 Medical Services Budget Target.

4.3.3 Acuity Adjustment

4.3.3.1 The parties hereby agree that the aggregate base line acuity for the population administered by the CONTRACTOR shall be based on a methodology recommended by the State or its actuarial contractor.

4.3.3.2 The Parties further agree that the ability of the CONTRACTOR to achieve these initiatives is directly and materially related to said base line acuity of the aggregate population described above. As an integral part of evaluating the CONTRACTOR’s performance in achieving the goals set forth above, the CONTRACTOR and TennCare shall perform a quarterly follow-up acuity review of the aggregate population described above. The CONTRACTOR and TennCare shall perform a reconciliation of aggregate acuity of the CONTRACTOR’s assigned population described above and show compliance with the Shared Risk Initiatives adjusting for changes in acuity population and supply said adjustment data to TENNCARE for review and approval on a quarterly basis. The adjusted base line numbers for acuity shall serve as the standard for the determination as to whether the CONTRACTOR achieved the Shared Risk Initiatives.

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4.3.4 **Mandates / Initiatives**

In addition, the Parties hereby agree that the determination of achieving compliance with the above Shared Risk Initiatives shall be consistent with the obligations of this Agreement as they are performed and interpreted as of March 1, 2009. As such, services provided as a result of compliance with an instruction or mandate from the TennCare Bureau that is in conflict with, or in excess of, those obligations pursuant to this Agreement as of March 1, 2009 shall be taken into account and not counted against the Contractor in determining the achievement of the Shared Risk Initiatives.

4.3.5 **Risk Component**

4.3.5.1 The Shared Risk Model will require that a percent of the administrative fees be placed at risk. The Model will set ten percent (10%) of the administrative fee at risk.

4.3.5.2 The Shared Risk Initiatives are listed below along with its associated risk contribution.

Shared Risk Initiative	Contribution to Risk
EPSDT Compliance	5.0%
Medical Services Budget Target	5.0%

4.3.5.2.1 *Increase EPSDT Compliance*

4.3.5.2.1.1 The target is based on the CONTRACTOR's reported screening rate according to the information contained in the CMS 416 Report for FFY 2007 which is 85%.

4.3.5.2.1.2 The goal is to insure that all children under the age of twenty-one (21) are receiving screenings consistent with the periodicity schedule referenced in the Agreement.

4.3.5.2.1.3 TENNCARE shall use the CMS 416 format in order to measure the CONTRACTOR's progress on a quarterly basis. In order to encourage continued progress, the administrative rate shall be reconciled in accordance with the following:

<u>Percentage of EPSDT Compliance Benchmark</u>	<u>Administrative Fee Adjustment</u>
≥ 100%	All admin assoc with EPSDT Screening rate compliance risk portion and potential bonus
≥ 95% and < 100%	-25% of admin assoc EPSDT Screening rate compliance risk portion
≥ 90% and < 95%	-50% of admin assoc EPSDT Screening rate compliance risk portion
≥ 85% and < 90%	-75% of admin assoc EPSDT Screening rate compliance risk portion
< 85% and lower	-100% of admin assoc EPSDT Screening rate compliance risk portion

Evaluation Period: Annually with a 90 day lag

At Risk Portion: 5.0% of Administrative Fee (Budget)

Implementation Date: March 1, 2009

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4.3.5.2.2 *Medical Services Budget Target Initiative*

4.3.5.2.2.1 At the end of the evaluation period associated with the MSBT, if the actual medical costs + IBNR is less than or equal to 100% of the MSBT, the CONTRACTOR shall retain 100% of the administrative fee associated with the MSBT. If the actual medical costs + IBNR is more than 100% of the MSBT, the CONTRACTOR's administrative fee associated with the MSBT shall be adjusted in accordance with the chart below. The estimated IBNR shall be reviewed and adjusted by the State's actuarial contractor prior to final determination of performance. The Table below illustrates the risk corridors for the Medical Services Budget target:

Percent of MSBT	Administrative Fee Adjustment
< 102%	All admin assoc with MSBT at risk portion and potential bonus
> 102% and ≤ 105%	-25% of admin assoc MSBT risk portion
> 105% and ≤ 110%	-50% of admin assoc MSBT risk portion
> 110% and ≤ 115%	-75% of admin assoc MSBT risk portion
> 115% and greater	-100% of admin assoc MSBT risk portion

Evaluation Period: Annual with a 90 day lag

At Risk Portion: 5% of Administrative Fee (Budget)

Implementation Date: March 1, 2009

4.3.6 **Performance Bonuses**

4.3.6.1 TennCare will establish a bonus pool for each Risk Initiative described below. The bonus pool will represent a total of ten percent (10%) of the administrative fee for the selected population (Group 1.A, Group 1.B, and Group 2) for the CONTRACTOR as described in Section 2.4 of this Agreement. The following Initiatives will be included in the Bonus Pool: EPSDT Compliance and Medical Service Budget Target (MSBT).

4.3.6.2 The following table identifies the weighting for each Initiative:

Shared Risk Initiative	Contribution to Bonus (% of Admin Rate for Selected Population)
EPSDT Compliance	5.0%
Medical Service Budget Target	5.0%

4.3.6.3 The following tables identify the Performance Percentage Targets:

Additional Bonus Points

Performance – Percent Exceeding Target	EPSDT Compliance Target
> 100% and ≤ 105%	25%
> 105% and ≤ 110%	60%
> 110% and ≤ 117%	100%

Performance – Percent Improving Target	Medical Services Budget Target
< 98% and ≥ 95%	25%
< 95% and ≥ 90%	50%
< 90% and ≥ 85%	75%
< 85%	100%

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4.3.7 Risk and Bonus Payout Reconciliation

- 4.3.7.1 The administrative fee will be paid in full on a monthly basis until such time the Evaluation Periods have occurred and determination has been made regarding the CONTRACTOR's compliance. Payouts for the annual evaluation period shall be made by October 31 of the following year.
- 4.3.7.2 In the event that the CONTRACTOR's progress on the various initiatives are different from what is determined by TennCare, the results (findings from both) will be reconciled during a fifteen (15) business day period following the due date of the submission by the Plan. If the dispute relates to medical cost and utilization based initiatives, TENNCARE shall request review by the Department of the Comptroller of the Treasury of said discrepancies. TennCare will submit an "On Request Report" (with a seven (7) day response time) to the CONTRACTOR in order for the CONTRACTOR to review and update or reprocess their data provided to TENNCARE. TENNCARE shall provide the outcome of the determination within eight (8) business days of receiving the information from the CONTRACTOR. If the information requested by TENNCARE is not provided by the due date, then the determination defaults to TENNCARE.
- 4.3.7.3 If targets are consistently exceeded (or not met) TENNCARE shall require that the CONTRACTOR submit a Corrective Action Plan to address the deficiencies.

4.4 HMO Payment

Payments to the CONTRACTOR shall be increased sufficiently to cover any additional amount due pursuant to Tennessee Code Annotated Section 56-32-124 thirty days after the end of each calendar year quarter. In the event the amount due pursuant to TCA 56-32-124 is increased during the term of this Agreement, the payments to the CONTRACTOR shall be increased by an amount equal to the increase in the amount due by the CONTRACTOR.

4.5 Payments to CONTRACTOR

The administrative fee payments and the premium tax payments specified in Section 4 and Attachment XVI of this Agreement as amended, shall represent payment in full. TennCare shall not reimburse CONTRACTOR for any costs, liquidated damages and/or penalties incurred by the CONTRACTOR and which result from actions or inactions, including penalties associated with CONTRACTOR's failure to timely pay any and all expenses, fees, taxes and other regulatory/ministerial costs associated with the requirements of operating as an HMO in this state. The taxes, fees, expenses, and other regulatory/ministerial costs referenced herein shall include but not be limited to premium taxes associated with any and all obligations required by the Tennessee Health Maintenance Organization Act of 1986 codified at Tennessee Code Annotated § 56-32-201 et seq. or any subsequent amendments thereto and/or the Tennessee Prepaid Limited Health Services Act of 2000 codified at Tennessee Code Annotated § 56-51-101 et seq. or any subsequent amendments thereto.

4.6 Maximum Liability

- 4.6.1 In no event shall the maximum liability of the State under this Agreement during the original term of the Agreement exceed Three Hundred Eighty Three Million, One Hundred Thirty Thousand Dollars (\$383,130,000.00).
- 4.6.2 If the Agreement maximum would be exceeded as a result of an increase in enrollment, a change in mix of enrollment among rate cells or any rate adjustment described herein, the State shall adjust the Agreement maximum liability to accommodate the aforementioned circumstances. This adjustment shall be based on consultation with the State's independent actuary.
- 4.6.3 This Agreement does not obligate the State to pay a fixed minimum amount and does not create in the CONTRACTOR any rights, interests or claims of entitlement in any funds.

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4.6.4 The CONTRACTOR is not entitled to be paid the maximum liability for any period under the Agreement or any extensions of the Agreement. The maximum liability represents available funds for payment to the CONTRACTOR and does not guarantee payment of these funds to the CONTRACTOR under this Agreement.

12. The renumbered Section 5.8.2.2 shall be amended by adding new Items B.25, B.26, B.27:

B.25	Failure to provide a written discharge plan or provision of a defective discharge plan for discharge from a psychiatric inpatient facility or mental health residential treatment facility as required in Section 2.9.6.3.2 of this Agreement	\$1,000 per occurrence per case
B.26	Failure to provide CRG/TPG assessments within the time frames specified in Section 2.6.5.9 of this Agreement	\$500 per month per Enrollee
B.27	Failure to provide CRG/TPG assessments by TDMHDD-certified raters or in accordance with TDMHDD policies and procedures as required in Section 2.6.5.9 of this Agreement	\$500 per occurrence per case

13. The existing Section 6-28 “Performance Guarantees” shall be deleted in its entirety and the newly renumbered Section 5 shall be amended by adding new Sections 5-28 through 5-33 and renumbering the existing Sections accordingly. The renumbered Section 5-33 shall be amended by deleting and replacing June 30, 2009 with June 30, 2010. The new and renumbered Sections shall read as follows:

5.28 Notice of Legal Action

The CONTRACTOR shall provide to TENNCARE and the Tennessee Department of Commerce and Insurance, TennCare Division, notice in writing by Certified Mail (or other means such as overnight delivery reasonably designed to document delivery) within five (5) business days of the CONTRACTOR being served with any administrative or legal action or complaint filed regarding any claim in law or equity made against the CONTRACTOR, or an affiliate of the CONTRACTOR (including but not limited to a parent company), that would materially impact either such affiliate's ability to operate its business or the CONTRACTOR's performance of duties hereunder. The Contractor shall also provide similar notice of any arbitration proceedings instituted between a provider and the CONTRACTOR. It is the intent of this provision that the CONTRACTOR notify TENNCARE of any and all actions described herein that may affect the CONTRACTOR'S financial viability and/or program operations or integrity.

5.29 CONTRACTOR Appeal Rights

The CONTRACTOR shall have the right to contest TENNCARE decisions pursuant to the provisions of TCA 9-8-301 et seq. for the resolution of disputes under this Agreement. Written notice describing the substance and basis of the contested action shall be submitted to TENNCARE within thirty (30) calendar days of the action taken by TENNCARE. The CONTRACTOR shall comply with all requirements contained within this Agreement pending the final resolution of the contested action.

5.30 Prohibition of Illegal Immigrants

The requirements of Public Acts of 2006, Chapter Number 878, of the state of Tennessee, addressing the use of illegal immigrants in the performance of any contract to supply goods or services to the state of Tennessee, shall be a material provision of this Agreement, a breach of which shall be grounds for monetary and other penalties, up to and including termination of this Agreement.

- 5.30.1 The Contractor hereby attests, certifies, warrants, and assures that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Agreement and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Agreement. The Contractor shall reaffirm this attestation, in writing, by submitting to the State a completed and signed copy of the document as Attachment II, hereto, semi-annually during the period of this Agreement. Such attestations shall be maintained by the contractor and made available to state officials upon request.
- 5.30.2 Prior to the use of any subcontractor in the performance of this Agreement, and semi-annually thereafter, during the period of this Agreement, the Contractor shall obtain and retain a current, written attestation that the subcontractor shall not knowingly utilize the services of an illegal immigrant to perform work relative to this Agreement and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant to perform work relative to this Agreement. Attestations obtained from such subcontractors shall be maintained by the contractor and made available to state officials upon request.
- 5.30.3 The Contractor shall maintain records for all personnel used in the performance of this Agreement. Said records shall be subject to review and random inspection at any reasonable time upon reasonable notice by the State.
- 5.30.4 The Contractor understands and agrees that failure to comply with this section will be subject to the sanctions of Public Chapter 878 of 2006 for acts or omissions occurring after its effective date. This law requires the Commissioner of Finance and Administration to prohibit a contractor from contracting with, or submitting an offer, proposal, or bid to contract with the State of Tennessee to supply goods or services for a period of one year after a contractor is discovered to have knowingly used the services of illegal immigrants during the performance of this contract.
- 5.30.5 For purposes of this Agreement, "illegal immigrant" shall be defined as any person who is not either a United States citizen, a Lawful Permanent Resident, or a person whose physical presence in the United States is authorized or allowed by the federal Department of Homeland Security and who, under federal immigration laws and/or regulations, is authorized to be employed in the U.S. or is otherwise authorized to provide services under the Agreement.

5.31 Voluntary Buyout Program

- 5.31.1 The Contractor acknowledges and understands that, for a period of two years beginning August 16, 2008, restrictions are imposed on former state employees who received a State of Tennessee Voluntary Buyout Program (VBP) severance payment with regard to contracts with state agencies that participated in the VBP.
- 5.31.2 The State will not contract with either a former state employee who received a VBP severance payment or an entity in which a former state employee who received a VBP severance payment or the spouse of such an individual holds a controlling financial interest.
- 5.31.3 The State may contract with an entity with which a former state employee who received a VBP severance payment is an employee or an independent contractor. Notwithstanding the foregoing, the Contractor understands and agrees that there may be unique business circumstances under which a return to work by a former state employee who received a VBP severance payment as an employee or an independent contractor of a State contractor would not be appropriate, and in such cases the State may refuse Contractor personnel. Inasmuch, it shall be the responsibility of the State to review Contractor personnel to identify any such issues.

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5.31.4 With reference to either subsection a. or b. above, a contractor may submit a written request for a waiver of the VBP restrictions regarding a former state employee and a contract with a state agency that participated in the VBP. Any such request must be submitted to the State in the form of the VBP Contracting Restriction Waiver Request format available from the State and the Internet at: www.state.tn.us/finance/rds/ocr/waiver.html. The determination on such a request shall be at the sole discretion of the head of the state agency that is a Party to this Agreement, the Commissioner of Finance and Administration, and the Commissioner of Human Resources.

5.32 Federal Economic Stimulus Funding

This Agreement requires the CONTRACTOR to provide products and/or services that are funded in whole or in part under the American Recovery and Reinvestment Act of 2009, Public Law 111-5, (Recovery Act). The CONTRACTOR is responsible for ensuring that all applicable requirements of the Recovery Act are met and that the CONTRACTOR provides information to the State as required by, but not limited to, the following:

5.32.1 The Recovery Act, including but not limited to the following sections of that Act:

5.32.1.1 Section 1606 – Wage Rate Requirements.

5.32.1.2 Section 1512 – Reporting and Registration Requirements.

5.32.1.3 Sections 902, 1514, and 1515 – General Accounting Office/Inspector General Access.

5.32.1.4 Section 1553 – Whistleblower Protections.

5.32.1.5 Section 1605 – Buy American Requirements for Construction Material.

5.32.2 Executive Office of the President, Office of Management and Budget (OMB) Guidelines as posted at http://www.whitehouse.gov/omb/recovery_default/, as well as OMB Circulars, including but not limited to A-102 and A-133 as posted at http://www.whitehouse.gov/omb/financial_offm_circulars/.

5.32.3 Federal Grant Award Documents.

5.32.4 Office of Tennessee Recovery Act Management Directives.

5.33 Contract Term of The Agreement

5.33.1 This Agreement and its incorporated attachments, if any, as well as all Amendments to this Agreement, contain all of the terms and conditions agreed upon by the parties, and when executed by all parties, supersedes any prior agreements. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall be in effect from July 1, 2001, subject to approval by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The term of this Agreement shall expire on June 30, 2010. At the mutual agreement of TennCare and the CONTRACTOR, this CONTRACT shall be renewable for an additional twelve month period.

5.33.2 Notwithstanding any provision herein to the contrary, the State may terminate this Agreement if the waiver governing TennCare is terminated. The documents referenced in the Agreement are on file with the CONTRACTOR and with TENNCARE and the CONTRACTOR is aware of their content. No other agreement, oral or otherwise regarding the subject matter of this Agreement, shall be deemed to exist or to bind any of the parties hereto.

- 14. Attachment I shall be deleted and replaced in its entirety so that the new Attachment I shall read as follows:**

**ATTACHMENT I
BEHAVIORAL HEALTH SPECIALIZED SERVICE DESCRIPTIONS**

The CONTRACTOR shall provide medically necessary mental health case management and psychiatric rehabilitation services according to the requirements herein.

SERVICE	Mental Health Case Management
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DEFINITION

Mental health case management is a supportive service provided to enhance treatment effectiveness and outcomes with the goal of maximizing resilience and recovery options and natural supports for the individual. Mental health case management is consumer-centered, consumer focused and strength-based, with services provided in a timely, appropriate, effective, efficient and coordinated fashion. It consists of activities performed by a team or a single mental health case manager to support clinical services. Mental health case managers assist in ensuring the individual/family access to services.

Mental health case management requires that the mental health case manager and the individual and/or family have a strong productive relationship which includes viewing the individual/family as a responsible partner in identifying and obtaining the necessary services and resources. Services rendered to children and youth shall be consumer-centered and family-focused with case managers working with multiple systems (e.g. education, child welfare, juvenile justice). Mental health case management is provided in community settings, which are accessible and comfortable to the individual/family. The service should be rendered in a culturally competent manner and be outcome driven. Mental health case management shall be available 24 hours a day, 7 days a week. The service is not time limited and provides the individual/family the opportunity to improve their quality of life.

The CONTRACTOR shall ensure mental health case management is rendered in accordance with all of the service components and guidelines herein.

SERVICE DELIVERY

The CONTRACTOR shall:

- Determine caseload size based on an average number of individuals per case manager, with the expectation being that case managers will have mixed caseloads of clients and flexibility between Levels 1 and 2 (Levels 1 and 2 are defined below); and
- Ensure that caseload sizes and minimum contacts are met as follows:

Case Management Type	Maximum Caseload Size	Minimum Face-to-Face Contacts
Level 1 (Non-Team Approach)*	25 individuals:1 case manager	One (1) contact per week
Level 1 (Team Approaches):		
Adult CTT	20 individuals:1 team 20 individuals:1 case manager	One (1) contact per week
Children & Youth (C&Y) CTT	15 individuals:1 team 15 individuals:1 case manager	One (1) contact per week
CCFT	15 individuals:1 team 15 individuals:1 case manager	One (1) contact per week
ACT	100 individuals:1 team 15 individuals:1 case manager	One (1) contact per week

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Case Management Type	Maximum Caseload Size	Minimum Face-to-Face Contacts
PACT	100 individuals:1 team 15 individuals:1 case manager	One (1) contact per week
Level 2*	35 individuals:1 case manager	Two (2) contacts per month

*For case managers having a combination of Level 1 & Level 2 (non-team) individuals, the maximum caseload size shall be no more than 30 individuals:1 case manager.

The CONTRACTOR shall ensure that the following requirements are met:

- 1) All mental health case managers shall have, at a minimum, a bachelor's degree;
- 2) Supervisors shall maintain no greater than a 1:30 supervisory ratio with mental health case managers;
- 3) Mental health case managers who are assigned to both a parent(s) and child in the same family, should have skills and experience needed for both ages; mental health case managers who are assigned to individuals with co-occurring disorders (mental illness and substance abuse disorders) should have the skills and experience to meet the needs of these individuals;
- 4) Eighty percent (80%) of all mental health case management services should take place outside the case manager's office;
- 5) The children and youth (C&Y) (under age eighteen (18)) mental health case management model shall provide a transition from C&Y services into adult services, including adult mental health case management services. The decision to serve an 18-year old youth via the C&Y case management system versus the adult system shall be a clinical one made by a provider. Transition from children's services, including mental health case management, shall be incorporated into the child's treatment plan; and
- 6) All mental health case management services shall be documented in a treatment plan. Mental health case management activities are correlated to expected outcomes and outcome achievement and shall be monitored, with progress being noted periodically in a written record.

Level 1

Level 1 mental health case management is the most intense level of service. It provides frequent and comprehensive support to individuals with a focus on recovery and resilience. The CONTRACTOR shall ensure the provision of level 1 mental health case management to the most severely disabled adults and emotionally disturbed children and youth, including individuals who are at high risk of future hospitalization or placement out of the home and require both community support and treatment interventions. Level 1 mental health case management can be rendered through a team approach or by individual mental health case managers. Team approaches may include such models as ACT, CTT, CCFT and PACT, as described below:

Assertive Community Treatment (ACT)

ACT is a way of delivering comprehensive and effective services to adults diagnosed with severe mental illness and who have needs that have not been well met by traditional approaches to delivering services. The principles of ACT include:

- 1) Services targeted to a specific group of individuals with severe mental illness;
- 2) Treatment, support and rehabilitation services provided directly by the ACT team;
- 3) Sharing of responsibility between team members and individuals served by the team;
- 4) Small staff (all team staff including case managers) to individual ratios (approx. 1 to 10);
- 5) Comprehensive and flexible range of treatment and services;
- 6) Interventions occurring in community settings rather than in hospitals or clinic settings;
- 7) No arbitrary time limit on receiving services;
- 8) Individualized treatment, support and rehabilitation services;
- 9) Twenty-four (24) hour a day availability of services; and
- 10) Engagement of individuals in treatment and monitoring.

Continuous Treatment Team (CTT)

CTT is a coordinated team of staff (to include physicians, nurses, case managers, and other therapists as needed) who provide a range of intensive, integrated mental health case management, treatment, and rehabilitation services

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to adults and children and youth. The intent is to provide intensive treatment to families of children and youth with acute psychiatric problems in an effort to prevent removal from the home to a more restrictive level of care. An array of services are delivered in the home or in natural settings in the community, and are provided through a strong partnership with the family and other community support systems. The program provides services including crisis intervention and stabilization, counseling, skills building, therapeutic intervention, advocacy, educational services, medication management as indicated, school based counseling and consultation with teachers, and other specialized services deemed necessary and appropriate.

Comprehensive Child and Family Treatment (CCFT)

CCFT services are high intensity, time-limited services designed for children and youth to provide stabilization and deter the “imminent” risk of State custody for the individual. There is usually family instability and high-risk behaviors exhibited by the child/adolescent. CCFT services are concentrated on child, family, and parental/guardian behaviors and interaction. CCFT services are more treatment oriented and situation specific with a focus on short-term stabilization goals. The primary goal of CCFT is to reach an appropriate point of stabilization so the individual can be transitioned to a less intense outpatient service.

Program of Assertive and Community Treatment (PACT)

PACT is a service delivery model for providing comprehensive community-based treatment to adults with severe and persistent mental illness. It involves the use of a multi-disciplinary team of mental health staff organized as an accountable, mobile mental health agency or group of providers who function as a team interchangeably to provide the treatment, rehabilitation and support services persons with severe and/or persistent mental illnesses need to live successfully in the community.

Level 2

Level 2 mental health case management is a less intensive level of service than Level 1 and is focused on resilience and recovery. The CONTRACTOR shall ensure that level 2 mental health case management is provided to individuals whose symptoms are at least partially stabilized or reduced in order to allow treatment and rehabilitation efforts.

Amendment Number 20 (cont.)

SERVICE COMPONENTS

The CONTRACTOR shall ensure that mental health case management incorporates the following service components:

Crisis Facilitation

Crisis facilitation is provided in situations requiring immediate attention/resolution for a specific individual or other person(s) in relation to a specific individual. It is the process of accessing and coordinating services for an individual in a crisis situation to ensure the necessary services are rendered during and following the crisis episode. Most crisis facilitation activities would involve face-to-face contact with the individual.

Assessment of Daily Functioning

Assessment of daily functioning involves the on-going monitoring of how an individual is coping with life on a day to day basis for the purposes of determining necessary services to maintain community placement and improve level of functioning. Most assessments of daily functioning are achieved by face-to-face contact with the individual in his or her natural environment.

Assessment/Referral/Coordination

Assessment/referral/coordination involves assessing the needs of the individual for the purposes of referral and coordination of services that will improve functioning and/or maintain stability in the individual's natural environment.

Mental Health Liaison

Mental health liaison services are offered to persons who are not yet assigned to mental health case management. It is a short-term service for the purposes of service referral and continuing care until other mental health services are initiated.

SERVICE	Psychiatric Rehabilitation
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DEFINITION

Psychiatric rehabilitation is an array of consumer-centered recovery services designed to support the individual in the attainment or maintenance of his or her optimal level of functioning. These services are designed to capitalize on personal strengths, develop coping skills and strategies to deal with deficits and develop a supportive environment in which to function as independent as possible on the individual's recovery journey.

Services included under psychiatric rehabilitation are as follows.

SERVICE COMPONENTS

Psychosocial Rehabilitation

Psychosocial rehabilitation services utilize a comprehensive approach (mind, body, and spirit) to work with the whole person for the purposes of improving an individuals' functioning, promoting management of illness(s), and facilitating recovery. The goal of psychosocial rehabilitation is to support individuals as active and productive members of their communities. Individuals, in partnership with staff, form goals for skills development in the areas of vocational, educational, and interpersonal growth (e.g. household management, development of social support networks) that serve to maximize opportunities for successful community integration. Individuals proceed toward goal attainment at their own pace and may continue in the program at varying levels intensity for an indefinite period of time.

Supported Employment

Supported employment consists of a range of services to assist individuals to choose, prepare for, obtain, and maintain gainful employment that is based on individuals' preferences, strengths, and experiences. This service also includes a variety of support services to the individual, including side-by-side support on the job. These services may be integrated into a psychosocial rehabilitation center.

Peer Support

Peer support services allow individuals to direct their own recovery and advocacy process and are provided by persons who are or have been consumers of the behavioral health system and their family members and are Certified Peer Support Specialists. These services include providing assistance with more effectively utilizing the service delivery system (e.g. assistance in developing plans of care, accessing services and supports, partnering with professionals) or understanding and coping with the stressors of the person's illness through support groups, coaching, role modeling, and mentoring. Activities which promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills are rendered so individuals can educate and support each other in the acquisition of skills needed to manage their illnesses and access resources within their communities. Services are often provided during the evening and weekend hours.

Illness Management & Recovery

Illness management and recovery services refers to a series of weekly sessions with trained mental health practitioners for the purpose of assisting individuals in developing personal strategies for coping with mental illness and promoting recovery.

Supported Housing

Supported housing services refers to services rendered at facilities that are staffed twenty-four (24) hours per day, seven (7) days a week with associated mental health staff supports for individuals who require treatment services and supports in a highly structured setting. These mental health services are for persons with serious and/or persistent mental illnesses (SPMI) and are intended to prepare individuals for more independent living in the community while providing an environment that allows individuals to live in community settings. Given this goal, every effort should be made to place individuals in facilities near their families and other support systems and

original areas of residence. Supported housing services are mental health services and do not include the payment of room and board.

15. Attachment IV shall be amended by adding “Psychiatry (adult), Psychiatry (child and adolescent)” to sub-section (1) and by adding the following in the Specialty/Non-Dual Members Grid:

Specialty	Number of Non-Dual Members
Psychiatry (adult)	25,000
Psychiatry (child & adolescent)	150,000

16. The Attachments shall be amended by adding a new Attachment V and renumbering the existing Attachments. The new Attachment V shall read as follows:

**ATTACHMENT V
ACCESS & AVAILABILITY FOR BEHAVIORAL HEALTH SERVICES**

The CONTRACTOR shall adhere to the following behavioral health network requirements to ensure access and availability to behavioral health services for all members (adults and children). For the purpose of assessing behavioral health provider network adequacy, TENNCARE will evaluate the CONTRACTOR’s provider network relative to the requirements described below. Providers serving adults will be evaluated separately from those serving children.

Access to Behavioral Health Services

The CONTRACTOR shall ensure access to behavioral health providers for the provision of covered services. At a minimum, this means that:

The CONTRACTOR shall have provider agreements with providers of the services listed in the table below and meet the geographic and time for admission/appointment requirements.

Service Type	Geographic Access Requirement	Maximum Time for Admission/ Appointment
Psychiatric Inpatient Hospital Services	Travel distance does not exceed 60 miles for at least 75% of members and does not exceed 90 miles for at least 90% of members	4 hours (emergency involuntary)/24 hours (involuntary)/24 hours (voluntary)
24 Hour Psychiatric Residential Treatment	Travel distance does not exceed 75 miles for at least 75% of ADULT members and does not exceed 150 miles for at least 90% of ADULT members ----- --- Travel distance does not exceed 60 miles for at least 75% of CHILD members and does not exceed 90 miles for at least 90% of CHILD members	Within 30 calendar days
Outpatient Non-MD Services	Travel distance does not exceed 30 miles for ALL members	Within 14 calendar days; if urgent, within 3 business days

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Intensive Outpatient (may include Day Treatment (adult), Intensive Day Treatment (Children & Adolescent) or Partial Hospitalization)	Travel distance does not exceed 60 miles for at least 75% of members and does not exceed 90 miles for at least 90% of members	Within 14 calendar days; if urgent, within 3 business days
Inpatient Facility Services (Substance Abuse)	Travel distance does not exceed 60 miles for at least 75% of members and does not exceed 90 miles for at least 90% of members	Within 2 calendar days; for detoxification - within 4 hours in an emergency and 24 hours for non-emergency
24 Hour Residential Treatment Services (Substance Abuse)*	Travel distance does not exceed 75 miles for at least 75% of members and does not exceed 120 miles for at least 90% of members	Within 14 calendar days
Outpatient Treatment Services (Substance Abuse)	Travel distance does not exceed 30 miles for ALL members	Within 14 calendar days; for detoxification – within 24 hours
Mental Health Case Management	Not subject to geographic access standards	Within 7 calendar days
Psychosocial Rehabilitation (may include Supported Employment, Illness Management & Recovery, or Peer Support (TDMHDD Rule Chapter 1940-5-29))	Not subject to geographic access standards	Within 14 calendar days
Supported Housing	Travel distance does not exceed 60 miles for at least 75% of ADULT members and does not exceed 90 miles for at least 90% of ADULT members	Within 30 calendar days
Crisis Services (Mobile)	Not subject to geographic access standards	Face-to-face contact within 1 hour for emergency situations and 4 hours for urgent situations
Crisis Stabilization	Not subject to geographic access standards	Within 4 hours of referral

*24 Hour Residential Treatment Substance Abuse Services may be provided by facilities licensed by the Tennessee Department of Health as Halfway House Treatment Facilities (DOH Rule Chapter 1200-8-17), Residential Detoxification Treatment Facilities (DOH Rule Chapter 1200-8-22) or Residential Rehabilitation Treatment Facilities (DOH Rule Chapter 1200-8-23). (Effective 1/1/2008, the Tennessee Department of Mental Health and Developmental Disabilities will license these facilities.)

When the above standards are not met, an acceptable Corrective Action Plan will be requested which details the CONTRACTOR’s intended course of action to resolve any deficiency (ies) identified. The Bureau of TennCare will evaluate Corrective Action Plans and, at its sole discretion, determine network adequacy considering any alternate measures and documentation of unique market conditions.

At a minimum, providers for the following service types shall be reported on the Provider Enrollment File:

Service Type	Service Code(s) for use in position 330-331 of the Provider Enrollment File
Psychiatric Inpatient Hospital Services	Adult - 11, 79, 85 Child – A1 or H9
24 Hour Psychiatric Residential Treatment	Adult - 13, 81, 82 Child – A9, H1, or H2
Outpatient MD Services (Psychiatry)	Adult – 19 Child – B5
Outpatient Non-MD Services	Adult – 20 Child – B6
Intensive Outpatient/ Partial Hospitalization	Adult – 21, 23, 62 Child - B7, C2, C3
Inpatient Facility Services (Substance Abuse)	Adult – 15, 17 Child – A3, A5
24 Hour Residential Treatment Services (Substance Abuse)	Adult - 56 Child - F6
Outpatient Treatment Services (Substance Abuse)	Adult – 27 or 28 Child – D3 or D4
Mental Health Case Management	Adult - 31, 66, or 83 Child – C7, D7, G2, G6, or K1
Psychiatric Rehabilitation Services:	
Psychosocial Rehabilitation	42
Supported Employment	44
Peer Support	88
Illness Management & Recovery	91
Supported Housing	32 and 33
Crisis Services (Mobile)	Adult - 37, 38, 39 Child - D8, D9, E1
Crisis Respite	Adult – 40 Child – E2
Crisis Stabilization	Adult – 41

17. The renumbered Attachment XII shall be deleted and replaced in its entirety.

**ATTACHMENT XII
Cost-Sharing Schedules**

**Non-Pharmacy Copayment Schedule
(unless otherwise directed by TENNCARE)**

Poverty Level	Copayment Amounts
0% - 99%	\$0.00
100% - 199%	\$10.00, Hospital Emergency Room (waived if admitted) \$5.00, Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care \$5.00, Physician Specialists (including Psychiatrists) \$5.00, Prescription or Refill \$5.00, Inpatient Hospital Admission (waived if readmitted within 48 hours for the same episode)
200% and above	\$5.00, Hospital Emergency Room (waived if admitted) \$15.00, Primary Care Provider and Community Mental Health

	Agency Services Other Than Preventive Care \$20.00, Physician Specialists (including Psychiatrists) \$10.00, Prescription or Refill \$100.00, Inpatient Hospital Admission (waived if readmitted within 48 hours for the same episode)
--	--

The CONTRACTOR is specifically prohibited from waiving or discouraging TENNCARE enrollees from paying the amounts described in this attachment.

18. The renumbered Attachment XIII, Exhibit D shall be deleted and replaced in its entirety and shall read as follows:

**ATTACHMENT XIII, EXHIBIT G
REPORT OF ESSENTIAL HOSPITAL SERVICES**

Instructions for Completing *Report of Essential Hospital Services*

The chart for the *Report of Essential Hospital Services* required in Section 2.30.7.4 is to be prepared based on the CONTRACTOR’s provider network for essential hospital services in each Grand Region in which the CONTRACTOR has (or expects to have) TennCare members.

- Fill out one report for each Grand Region. In the top portion of the grid, indicate the MCO name, the Grand Region, the total number of MCO members in the Grand Region and the date that such total enrollment was established.
 - Provide information on each contract and non-contract facility that serves (or will serve) members in the identified Grand Region. The MCO should use a separate row to report information on each such facility.
1. In the first column, “Name of Facility” indicate the complete name of the facility.
 2. In the second column, “TennCare ID” indicate the TennCare ID assigned to the facility.
 3. In the third column, “NPI” indicate the National Provider Identifier in which issued to the facility.
 4. In the fourth column, “City/Town” indicate the city or town in which the designated facility is located.
 5. In the fifth column, “County”, indicate the name of the county in which this facility is located.
 6. In the sixth through the thirteenth columns indicate the status of the CONTRACTOR’s relationship with the specific facility for each of these covered hospital services, e.g. Neonatal, Perinatal, Pediatric, Trauma, Burn, Center of Excellence for AIDS, Center of Excellence for Children at Risk or in State Custody and Centers of Excellence for Behavioral Health. For example:
 - If the CONTRACTOR has an executed provider agreement with the facility for neonatal services, insert an “E” in the column labeled “Neonatal”.
 - If the CONTRACTOR does not have an executed provider agreement with this facility for “Neonatal”, but has another type of arrangement with this facility, the CONTRACTOR should indicate the code that best describes its relationship (L=letter of intent; R=on referral basis; N=in contract negotiations; O=other arrangement). For any facility in which the CONTRACTOR does not have an executed provider agreement and is using as a non-contract provider, the CONTRACTOR should submit a brief description (one paragraph) of its relationship with the facility including an estimated timeline for executing a provider agreement, if any.
 - If the CONTRACTOR does not have any relationship for neonatal services with the facility on this row, the CONTRACTOR should leave the cell labeled “neonatal” blank.

**ATTACHMENT XIII, EXHIBIT G
ESSENTIAL HOSPITAL SERVICES REPORT**

MCO Name:		Grand Region:			
Number of TennCare Members:		as of (date):			

Name of Facility	TennCare ID	NPI	City/ Town	County	Neonatal	Perinatal	Pediatric	Trauma	Burn	AIDS Center of Excellence	Center of Excellence for Children at Risk or in State Custody	Center of Excellence for Behavioral Health	Comments

E = Executed Provider Agreement
 L = Letter of Intent
 R = On Referral Basis
 N = In Contract Negotiations
 O = Other Arrangement

If no relationship for a particular service leave cell blank

- 19. The renumbered Attachment XIII shall be amended by adding new Exhibits O, P and Q which shall read as follows:**

**ATTACHMENT XIII, EXHIBIT O
MENTAL HEALTH CASE MANAGEMENT REPORT**

The *Mental Health Case Management Report* required in Section 2.30.4.2 shall include, at a minimum, the following data elements:

1. MCO ID number
2. Number and percentage of compliance for appointments scheduled within 7 calendar days of the date of discharge from psychiatric inpatient or residential treatment facility
3. Number and percentage of compliance for appointments occurring within 7 calendar days of the date of discharge from psychiatric inpatient or residential treatment facility, excluding member no shows, reschedules, and refusals
4. Number and percentage of appointment no shows
5. Number and percentage of appointment reschedules
6. Number and percentage of members meeting medical necessity for mental health case management and refusing the service
7. Data elements #2 - #6 broken down by mental health case management agency
8. DCS status

**ATTACHMENT XIII, EXHIBIT P
BEHAVIORAL HEALTH CRISIS RESPONSE REPORT**

The *Behavioral Health Crisis Response Report* required in Section 2.30.4.4 shall include, at a minimum, the following data elements:

1. Total Telephone Contacts
2. Type of Call: Psychiatric Emergency
3. Type of Call: Urgent
4. Type of Call: Routine
5. Total Face-to-Face Contacts
6. Face-to-Face Type: Psychiatric Emergency
7. Face-to-Face Type: Urgent
8. Face-to-Face Type: Routine
9. Total Face-to-Face Contacts by Payor
10. Face-to-Face Payor Source: TennCare
11. Face-to-Face Payor Source: Medicare
12. Face-to-Face Payor Source: Commercial
13. Face-to-Face Payor Source: None
14. Total Face-to-Face Contacts by Location
15. Face-to-Face Location: Onsite at CMHA
16. Face-to-Face Location: ER
17. Face-to-Face Location: Other Offsite
18. Total Face-to-Face Contacts by Disposition
19. Disposition: Total Admitted to RMHI (acute)
20. # Admitted to RMHI Not Mandatory Pre-Screened
21. Disposition: Total Admitted to Other Inpt (acute) Includes Dual Dx
22. # Admitted To Other Inpt Not Mandatory Pre-Screened
23. GRAND TOTAL PSYCHIATRIC ADMISSIONS
24. Disposition: Admitted to IP SA Treatment
25. Disposition: Referred to Lower Level OP Care
26. Disposition: Referred to Respite Services
27. Average time for Admission to Crisis Respite (only when admitted to respite)
28. Disposition: Referred to Other Services

Amendment Number 20 (cont.)

29. Disposition: Assessed / No Need for Referral
30. Disposition: Consumers Refusing Referral
31. Total Number of Face-to-Face Contacts for C&A <18 yrs of age
32. Total Number of Face-to-Face Contacts for C&A 18 to <21 yrs of age
33. Total Number of Face-to-Face Contacts for Adults 21 yrs and older
34. Total Number of Behavioral Health Providers notified of Crisis (only if consumer has a provider)
35. Average Time of Arrival in Minutes: Psychiatric Emergency
36. Average Time of Arrival in Minutes: Urgent
37. Barriers to Diversion: No Psychiatric Respite Accessible
38. Barriers to Diversion: No SA/Dual Respite Accessible
39. Barriers to Diversion: Consumer/Guardian Refused Respite
40. Barriers to Diversion: 6-404 Signed Prior to Assessment (when consumer could have been diverted if CON not signed)
41. Barriers to Diversion: Lack of Linkage w/Case Mgr (only if consumer has a CM)
42. Barriers to Diversion: Other (only for inappropriate admissions and barrier does not fit in any other category)

**ATTACHMENT XIII, EXHIBIT Q
MEMBER CRG/TPG ASSESSMENT REPORT**

The *Member CRG/TPG Assessment Report* required in Section 2.30.4.5 shall include, at a minimum, the following data elements:

CRG assessment of members age 18 years or older

1. MCO's ID number
2. Member's last name
3. Member's first name
4. Member's birth date
5. Member's Social Security Number (SSN)
6. Principal diagnosis
7. Dual principal/secondary diagnosis
8. Measure of member's level of functioning in activities of daily living
9. Measure of member's level of functioning in interpersonal functioning
10. Measure of member's level of functioning in concentration, task performance, and pace
11. Measure of member's level of functioning in adaptation to change
12. Measure of member's severity of impairment
13. Measure of member's duration of mental illness
14. Indicator of member's former severe impairment
15. Member's need for services to prevent relapse
16. Member's Clinically Related Group (CRG)
17. Reason for assessment
18. Date of request for assessment
19. Date of CRG assessment
20. Measure of rater's adequacy of information in order to complete assessment
21. Member's current Global Assessment of Functioning (GAF) scale score
22. Member's highest GAF scale score (past year)
23. Member's lowest GAF scale score (past year)
24. Program code
25. Rater's TennCare provider ID number

TPG assessment of members under age 18

1. MCO's ID number
2. Member's last name
3. Member's first name
4. Member's date of birth
5. Member's social security number

Amendment Number 20 (cont.)

6. Principal diagnosis
7. Dual principal/secondary diagnosis
8. Member's current Global Assessment of Functioning (GAF) scale score
9. Member's highest GAF scale score (past year)
10. Member's lowest GAF scale score (past year)
11. Severity of impairment
12. Serious Emotional Disturbance (SED) status
13. Environmental issues
14. Family issues
15. Trauma issues
16. Social skills issues
17. Abuse/neglect issues
18. Child at risk of SED
19. Member's Target Population Group (TPG)
20. Reason for assessment
21. Date of request for assessment
22. Date of TPG assessment
23. Measure of rater's adequacy of information in order to complete assessment
24. Program code
25. Rater's TennCare provider ID number

- 20. The Attachments shall be amended by adding new Attachments XV and XVI which shall read as follows:**

**ATTACHMENT XV
PERFORMANCE STANDARDS**

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
1	Timely Claims Processing	Report from TDCI	90% of claims (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) calendar days of the receipt of claim. 99.5% of claims are processed within sixty (60) calendar days.	Percentage of claims paid within 30 calendar days of receipt of claim, for each month Percentage of claims processed within 60 calendar days of receipt of claim, for each month	Monthly	\$10,000 for each month determined not to be in compliance
2	Claims Payment Accuracy	Self-reported results based on an internal audit conducted on a statistically valid random sample will be validated by TDCI	97% of claims paid accurately upon initial submission	Percentage of total claims paid accurately; for each month	Monthly	\$5,000 for each full percentage point accuracy is below 97% for each month
3	Telephone Response Time/Call Answer Timeliness -Member Services Line	Member Services and UM Phone Line Report	85% of all calls to each line are answered by a live voice within thirty (30) seconds or the prevailing benchmark established by NCQA	The number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the phone line (during hours of operation) during the measurement period	Quarterly	\$25,000 for each full percentage point below 85% per month
4	Telephone Response Time/Call Answer Timeliness - Utilization Management Line	Member Services and UM Phone Line Report	85% of all calls to each line are answered by a live voice within thirty (30) seconds or the prevailing benchmark established by NCQA	The number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the phone line (during hours of operation) during the measurement period	Quarterly	\$25,000 for each full percentage point below 85% per month

Amendment Number 20 (cont.)

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
5	Telephone Call Abandonment Rate (unanswered calls) – Member Services Line	Member Services and UM Phone Line Report	Less than 5% of telephone calls are abandoned	The number of calls abandoned by the caller or the system before being answered by a live voice divided by the number of calls received by the phone line (during open hours of operation) during the measurement period	Quarterly	\$25,000 for each full percentage point above 5% per month
6	Telephone Call Abandonment Rate (unanswered calls) – UM Line	Member Services and UM Phone Line Report	Less than 5% of telephone calls are abandoned	The number of calls abandoned by the caller or the system before being answered by a live voice divided by the number of calls received by the phone line (during open hours of operation) during the measurement period	Quarterly	\$25,000 for each full percentage point above 5% per month

Amendment Number 20 (cont.)

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
7	Provider Network Documentation	Provider Enrollment File and provider agreement signature pages	100% of providers on the Provider Enrollment File have a signed provider agreement with the CONTRACTOR		Upon TENNCARE request	\$1,000 for each provider for which the CONTRACTOR cannot provide a signature page from the provider agreement between the provider and the CONTRACTOR

Amendment Number 20 (cont.)

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
8	Specialist Provider Network	Provider Enrollment File	<p><u>1. Physician Specialists:</u> Executed specialty physician contracts in all areas required by this Agreement for the following specialists: allergy; cardiology; dermatology; endocrinology; gastroenterology; general surgery; nephrology; neurology; neurosurgery; otolaryngology; ophthalmology; orthopedics; oncology/hematology; psychiatry (adults); psychiatry (child/adolescent); and urology</p> <p><u>2. Essential Hospital Services:</u> Executed contract with at least one (1) tertiary care center for each essential hospital service</p> <p><u>3. Center of Excellence for People with AIDS:</u> Executed contract with at least two (2) Center of Excellence for AIDS within the CONTRACTOR's approved Grand Region(s)</p> <p><u>4. Center of Excellence for Behavioral Health:</u> Executed contract with all COEs for Behavioral Health within the CONTRACTOR's approved Grand Region(s)</p>	Executed contract is a signed provider agreement with a provider to participate in the CONTRACTOR's network as a contract provider	Monthly	<p>\$25,000 if ANY of the listed standards are not met, either individually or in combination on a monthly basis</p> <p>The liquidated damage may be waived for Physician Specialists if the CONTRACTOR provides sufficient documentation to demonstrate that the deficiency is attributable to a lack of physicians practicing in the area. The liquidated damage may be lowered to \$5,000 in the event the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE</p>

Amendment Number 20 (cont.)

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
9	Provider Participation Accuracy	Provider Enrollment File	At least 90% of listed providers confirm participation in the CONTRACTOR's network	A statistically valid sample of participating providers on the most recent monthly provider enrollment file confirm that they are participating in the CONTRACTOR's network	Quarterly	\$25,000 per quarter if less than 90% of providers confirm participation. The liquidated damage may be lowered to \$5,000 in the event that the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE, or may be waived by TENNCARE if the CONTRACTOR submits sufficient documentation to demonstrate 90% of providers in the sample are participating
10	Provider Information Accuracy	Provider Enrollment File	Data for no more than 10% of listed providers is incorrect for <u>each</u> data element	Data for no more than 10% of a statistically valid sample of participating providers on the most recent monthly provider enrollment is incorrect for <u>each</u> element as determined by TENNCARE	Quarterly	\$5,000 per quarter if data for more than 10% but fewer than 31% of providers is incorrect for <u>each</u> data element \$25,000 per quarter if data for more than 30% of providers is incorrect for <u>each</u> data element The \$25,000 liquidated damage may be lowered to \$5,000 in the event that the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE, or may be waived by TENNCARE if the CONTRACTOR submits sufficient documentation

Amendment Number 20 (cont.)

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
11	Distance from provider to member	Provider Enrollment File	In accordance with this Agreement, including Attachments III through V	Time and travel distance as measured by GeoAccess	Monthly	\$25,000 if ANY of the listed standards are not met, either individually or in combination on a monthly basis. The liquidated damage may be lowered to \$5,000 in the event that the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE
12	Initial appointment timeliness for behavioral health services	Behavioral Health Initial Appointment Timeliness Report	85% of all initial appointments for behavioral health services for outpatient mental health services (MD and Non-MD) and outpatient substance abuse services shall meet the access and availability standards indicated in Attachment V	Average time between the intake assessment appointment and the member's next appointment scheduled or admission by type of service	Quarterly	\$2,000 for each service type for which less than 85% of all initial appointments for the specified provider types meet the access and availability standards indicated in Attachment V
13	Percentage of SPMI/SED members who receive a behavioral health service (excluding a CRG/TPG assessment)	Claims and encounter data	The percentage of SPMI/SED members who receive a behavioral health service (excluding a CRG/TPG assessment) will not be less than 76%	The number of SPMI/SED members receiving a behavioral health service (excluding a CRG/TPG assessment) during the fiscal year divided by the MCO's number of SPMI/SED members during the fiscal year is not less than the benchmark	Annually	\$25,000 for each year determined to not be in compliance
14	Non-IMD Inpatient Use	Behavioral Health Crisis Service Response Reports and utilization data	10% decrease of total inpatient days at freestanding psychiatric hospitals subject to IMD exclusion compared to the base year's utilization	Total inpatient psychiatric hospital days at IMD exclusion facilities for members reduced by 10% after base line year	Annually	\$10,000 for each year determined to not be in compliance

Amendment Number 20 (cont.)

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
15	TENnderCare Screening	MCO encounter data	TENnderCare screening ratio, 80%	The EPSDT screening ratio, calculated by TENNCARE utilizing MCO encounter data submissions in accordance with specifications for the CMS-416 report	Quarterly	\$5,000 for each full percentage point TENnderCare screening ratio is below 80% for the most recent rolling twelve month period
16	Increase in utilization of supported employment	Supported Employment Reports	15% of all adults (21 – 64 years of age) designated as SPMI actively receiving supported employment services will be gainfully employed in either part time or full time capacity for a continuous 90 day period within one (1) year of receiving supported employment services	Total number of SPMI adults receiving supported employment services as defined in Attachment I employed for a continuous 90-day period within one (1) year of receiving supported employment services divided by the total number of SPMI adults	Annually	\$25,000 for each year determined to not be in compliance
17	Generic Prescription Drug Utilization	Encounter data	Sixty percent (60%)	Number of generic prescriptions divided by the total number of prescriptions	Quarterly	\$5,000 for each full percentage point Generic Prescription Utilization ratio is below 60%
18	Length of time between psychiatric hospital/RTF discharge and first subsequent mental health case management service	Mental Health Case Management Report	90% of discharged members <i>receive</i> a mental health case management service as medically necessary within seven (7) calendar days of discharge, excluding situations involving member reschedules, no shows, and refusals	(1) Number of members discharged by length of time between discharge and first subsequent mental health case management service as medically necessary reported by CMHA and type of service received; determined for each month (2) Average length of time between hospital discharge and first subsequent medically necessary MHCM visit reported by CMHA and type of service received excluding member reschedules, no shows, and refusals; determined for each month	Quarterly	\$3,000 for each quarter determined to not be in compliance

Amendment Number 20 (cont.)

	PERFORMANCE MEASURE	DATA SOURCE(S)	BENCHMARK	DEFINITION	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
19	Seven (7) day readmission rate	Psychiatric Hospital/RTF Readmission Report	Not more than 10% of members discharged from an inpatient or residential facility are readmitted within seven (7) calendar days of discharge	Number of members discharged from an inpatient or residential facility divided by the number of members readmitted within seven (7) calendar days of discharge; determined for each month in the quarter	Quarterly	\$1,500 for each quarter determined to not be in compliance
20	Thirty (30) day readmission rate	Psychiatric Hospital/RTF Readmission Report	Not more than 15% of members discharged from an inpatient or residential facility are readmitted within thirty (30) calendar days of discharge	Number of members discharged from an inpatient or residential facility divided by the number of members readmitted within thirty (30) calendar days of discharge; determined for each month in the quarter	Quarterly	\$1,500 for each quarter determined to not be in compliance ^{IV} .
21	Members are satisfied with the services they receive from behavioral health providers	Annual consumer satisfaction survey administered by TDMHDD	85% of respondents rate their experience to be fair or better	Distribution of members by satisfaction score	Annually	\$10,000 for each response below 85%

**ATTACHMENT XVI
Administrative Fee Payments**

I. Administrative Fee Effective July 1, 2001 through December 31, 2002

Category	Effective July 1, 2001 – June 30, 2002	Effective July 1, 2002 – December 31, 2002
Group 1.A	\$21.84 PMPM	\$22.71 PMPM
Group 1.B	\$21.84 PMPM	\$22.71 PMPM
Group 2	\$21.84 PMPM	\$22.71 PMPM
Group 3	\$13.84 PMPM	\$14.39 PMPM
Group 4	\$13.84 PMPM	\$14.39 PMPM
Group 5	\$13.84 PMPM	\$14.39 PMPM
Group 6	\$13.84 PMPM	\$14.39 PMPM

II. Administrative Fee Effective January 1, 2003:

Group 1.A, Group 1.B, and Group 2

Category	Effective January 1, 2003
Group 1.A	\$25.00 PMPM
Group 1.B	\$25.00 PMPM
Group 2	\$25.00 PMPM

Group 3, Group 4, Group 5 and Group 6 shall vary based on the total number of enrollees in these groups as follows:

Enrollment Level	Administrative Fee
0 to 99,999 enrollees	\$11.37
100,000 to 199,999 enrollees	\$11.25
200,000 to 299,999 enrollees	\$11.12
300,000 to 399,999 enrollees	\$11.00
400,000 to 499,999 enrollees	\$10.89
500,000 to 599,999 enrollees	\$10.68
600,000 to 699,999 enrollees	\$10.53
700,000 to 799,999 enrollees	\$10.38
800,000 to 899,999 enrollees	\$10.23
900,000 to 999,999 enrollees	\$10.08
1,000,000 or more enrollees	\$9.93

III. Administrative Fee Effective January 1, 2006:

Group 1.A, Group 1.B, and Group 2

Category	Effective January 1, 2003
Group 1.A	\$25.20 PMPM
Group 1.B	\$25.20 PMPM
Group 2	\$25.20 PMPM

Group 3, Group 4, Group 5 and Group 6 shall vary based on the total number of enrollees in these groups as follows:

Amendment Number 20 (cont.)

Enrollment Level	Administrative Fee
0 to 99,999 enrollees	\$11.57
100,000 to 199,999 enrollees	\$11.45
200,000 to 299,999 enrollees	\$11.32
300,000 to 399,999 enrollees	\$11.20
400,000 to 499,999 enrollees	\$11.09
500,000 to 599,999 enrollees	\$10.88
600,000 to 699,999 enrollees	\$10.73
700,000 to 799,999 enrollees	\$10.58
800,000 to 899,999 enrollees	\$10.43
900,000 to 999,999 enrollees	\$10.28
1,000,000 or more enrollees	\$10.13

IV. Administrative Fee Effective September 1, 2009

Category	Effective September 1, 2009
Group 1.A	\$29.00 PMPM
Group 1.B	\$29.00 PMPM
Group 2	\$29.00 PMPM
Group 3	\$29.00 PMPM
Group 4	\$29.00 PMPM
Group 5	\$29.00 PMPM
Group 6	\$29.00 PMPM

Amendment Number 20 (cont.)

All of the provisions of the original Agreement not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective July 1, 2009.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: M. D. Goetz, Jr.
M. D. Goetz, Jr.
Commissioner

DATE: 6/30/09

VOLUNTEER STATE HEALTH PLAN, INC.

BY: Sonya Nelson
Sonya Nelson
President and Chief Executive Officer

DATE: 6/26/09

APPROVED BY:

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: M. D. Goetz, Jr.
M. D. Goetz, Jr.
Commissioner

DATE: 6/30/09

APPROVED BY:

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

BY: Justin P. Wilson
Justin P. Wilson
Comptroller

DATE: 7/9/09

CONTRACT SUMMARY SHEET

RFS Number:	318.66-026	Contract Number:	FA-02-14632-19
State Agency:	Department of Finance and Administration	Division:	Bureau of TennCare

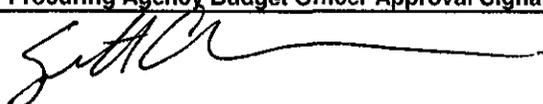
Contractor	Contract Identification Number
VSHP (TennCare Select)	<input type="checkbox"/> V- <input type="checkbox"/> C-

Service Description

Managed Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medicaid Population

Contract Begin Date	Contract End Date
7/1/2001	6/30/2009

Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66	4A2	134	11	<input type="checkbox"/> STARS		
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)	
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$	18,599,868.48
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$	33,079,942.80
2004	\$ 25,125,990.72	\$ 38,364,165.90			\$	63,490,156.62
2005	\$ 58,007,447.00	\$ 58,007,447.00			\$	116,014,894.00
2006	\$87,748,111.00	\$87,748,111.00			\$	\$175,496,222.00
2007	\$87,748,111.00	\$87,748,111.00			\$	\$175,496,222.00
2008	\$72,610,000.00	\$127,390,000.00			\$	\$200,000,000.00
2009	\$72,610,000.00	\$127,390,000.00			\$	\$200,000,000.00
Total:	\$ 426,390,720.35	\$ 555,786,585.55				\$982,177,305.90

CFDA#	93.778 Title XIX Dept. of Health & Human Svcs.	Check the box ONLY if the answer is YES:
State Fiscal Contract		Is the Contractor a SUBRECIPIENT? (per OMB A-133)
Name:	Scott Pierce	Is the Contractor a Vendor? (per OMB A-133)
Address:	310 Great Circle Road	Is the Fiscal Year Funding STRICTLY LIMITED?
Phone:	Nashville, TN (615)507-6415	Is the Contractor on STARS?
Procuring Agency Budget Officer Approval Signature		Is the Contractor's FORM W-9 ATTACHED?
Scott Pierce		Is the Contractor's Form W-9 Filed with Accounts?

COMPLETE FOR ALL AMENDMENTS (only)			Funding Certification
	Base Contract & Prior Amendments	This Amendment ONLY	Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered or pay obligations previously incurred.
CONTRACT END DATE:	6/30/2008	6/30/2009	
FY: 2002	\$ 18,599,868.48		
FY: 2003	\$ 33,079,942.80		
FY: 2004	\$ 63,490,156.62		
FY: 2005	\$116,014,894.00		
FY: 2006	\$175,496,222.00		
FY: 2007	\$175,151,878.00		
FY: 2008	\$200,000,000.00		
FY: 2009	\$200,000,000.00		
Total:	\$982,177,305.90		

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AMENDMENT NUMBER 19

**AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.**

CONTRACT NUMBER: FA-02-14632-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as follows:

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. Section 5-1 shall be amended by adding a new Section 5-1.k which shall read as follows:

k. Shared Risk Terms and Conditions

Effective March 1, 2009, the terms of the CONTRACTOR's shared risk responsibility shall be described below. The shared risk terms shall apply to the following populations as described in Section 4-1.1.a of this Contract: Group 1.A, Group 1.B, and Group 2.

The CONTRACTOR will be paid an administrative fee to administer the TennCare MCO benefits. Additionally, there will be both an upside potential (bonus) as well as downside potential (risk). Bonus and the risk will be based on the following components as described below:

EPSDT, and
Medical Services Budget Target.

(1) Acuity Adjustment

The parties hereby agree that the aggregate base line acuity for the population administered by the CONTRACTOR shall be based on a methodology recommended by the State or its actuarial contractor.

The Parties further agree that the ability of the CONTRACTOR to achieve these initiatives is directly and materially related to said base line acuity of the aggregate population described above. As an integral part of evaluating the CONTRACTOR's performance in achieving the goals set forth above, the CONTRACTOR and TennCare shall perform a quarterly follow-up acuity review of the aggregate population described above. The CONTRACTOR and TennCare shall perform a reconciliation of aggregate acuity of the CONTRACTOR's assigned population described above and show compliance with the Shared Risk Initiatives adjusting for changes in acuity population and supply said adjustment data to TENNCARE for review and approval on a quarterly basis. The adjusted base line numbers for acuity shall serve as the standard for the determination as to whether the CONTRACTOR achieved the Shared Risk Initiatives.

(2) Mandates / Initiatives

In addition, the Parties hereby agree that the determination of achieving compliance with the above Shared Risk Initiatives shall be consistent with the obligations of this Contract as they are performed and interpreted as of March 1, 2009. As such, services provided as a result of

compliance with an instruction or mandate from the TennCare Bureau that is in conflict with, or in excess of, those obligations pursuant to this Contract as of March 1, 2009 shall be taken into account and not counted against the Contractor in determining the achievement of the Shared Risk Initiatives.

(3) Risk Component

The Shared Risk Model will require that a percent of the administrative fees be placed at risk. The Model will set ten percent (10%) of the administrative fee at risk.

The Shared Risk Initiatives are listed below along with its associated risk contribution.

Shared Risk Initiative	Contribution to Risk
EPSDT Compliance	5.0%
Medical Services Budget Target	5.0%

(a) Increase EPSDT Compliance

The target for the period March 1, 2009 through June 30, 2009 is based on the CONTRACTOR's reported screening rate according to the information contained in the CMS 416 Report for FFY 2007 which is 85%.

The goal is to insure that all children under the age of twenty-one (21) are receiving screenings consistent with the periodicity schedule referenced in the Contract.

TENNCARE shall use the CMS 416 format in order to measure the CONTRACTOR's progress on a quarterly basis. In order to encourage continued progress, the administrative rate shall be reconciled in accordance with the following:

Percentage of EPSDT Compliance Benchmark	Administrative Fee Adjustment
≥ 100%	All admin assoc with EPSDT Screening rate compliance risk portion and potential bonus
≥ 95% and < 100%	-25% of admin assoc EPSDT Screening rate compliance risk portion
≥ 90% and < 95%	-50% of admin assoc EPSDT Screening rate compliance risk portion
≥ 85% and < 90%	-75% of admin assoc EPSDT Screening rate compliance risk portion
< 85% and lower	-100% of admin assoc EPSDT Screening rate compliance risk portion

Evaluation Period: Annually with a 90 day lag

At Risk Portion: 5.0% of Administrative Fee (Budget)

Implementation Date: March 1, 2009

(b) Medical Services Budget Target Initiative

At the end of the evaluation period associated with the MSBT, if the actual medical costs + IBNR is less than or equal to 100% of the MSBT, the CONTRACTOR shall retain 100% of the administrative fee associated with the MSBT. If the actual medical costs + IBNR is more than 100% of the MSBT, the CONTRACTOR's administrative fee associated with the MSBT shall be adjusted in accordance with the chart below. The estimated IBNR shall be reviewed and adjusted by the State's actuarial contractor prior to

final determination of performance. The Table below illustrates the risk corridors for the Medical Services Budget target:

Percent of MSBT	Administrative Fee Adjustment
≤ 102%	All admin assoc with MSBT at risk portion and potential bonus
> 102% and ≤ 105%	-25% of admin assoc MSBT risk portion
> 105% and ≤ 110%	-50% of admin assoc MSBT risk portion
> 110% and ≤ 115%	-75% of admin assoc MSBT risk portion
> 115% and greater	-100% of admin assoc MSBT risk portion

Evaluation Period: Annual with a 90 day lag

At Risk Portion: 5% of Administrative Fee (Budget)

Implementation Date: March 1, 2009

(4) Performance Bonuses

TennCare will establish a bonus pool for each Risk Initiative described below. The bonus pool will represent a total of ten percent (10%) of the administrative fee for the selected population (Group 1.A, Group 1.B, and Group 2) for the CONTRACTOR as described in Section 5-1 of this Contract. The following Initiatives will be included in the Bonus Pool: EPSDT Compliance and Medical Service Budget Target (MSBT).

The following table identifies the weighting for each Initiative:

Shared Risk Initiative	Contribution to Bonus (% of Admin Rate for Selected Population)
EPSDT Compliance	5.0%
Medical Service Budget Target	5.0%

Additional Bonus Points

Performance - Percent Exceeding Target	EPSDT Compliance Target
> 100% and ≤ 105%	25%
> 105% and ≤ 110%	60%
> 110% and ≤ 117%	100%

Performance - Percent Improving Target	Medical Services Budget Target
< 98% and ≥ 95%	25%
< 95% and ≥ 90%	50%
< 90% and ≥ 85%	75%
< 85%	100%

(5) Risk and Bonus Payout Reconciliation

The administrative fee will be paid in full on a monthly basis until such time the Evaluation Periods have occurred and determination has been made regarding the CONTRACTOR's compliance. Payouts for the annual evaluation period shall be made by October 31 of the following year.

In the event that the CONTRACTOR's progress on the various initiatives are different from what is determined by TennCare, the results (findings from both) will be reconciled during a fifteen (15) business day period following the due date of the submission by the Plan. If the dispute relates to medical cost and utilization based initiatives, TENNCARE shall request review by the Department of the Comptroller of the Treasury of said discrepancies. TennCare will submit an "On Request Report" (with a seven (7) day response time) to the CONTRACTOR in order for the CONTRACTOR to review and update or reprocess their data provided to TENNCARE. TENNCARE shall provide the outcome of the determination within eight (8) business days of receiving the information from the CONTRACTOR. If the information requested by TENNCARE is not provided by the due date, then the determination defaults to TENNCARE.

If targets are consistently exceeded (or not met) TENNCARE shall require that the CONTRACTOR submit a Corrective Action Plan to address the deficiencies.

2. Section 6 shall be amended by adding a new Section 6.29 which shall read as follows:

6-29 Voluntary Buyout Program

The Contractor acknowledges and understands that, for a period of two years beginning August 16, 2008, restrictions are imposed on former state employees who received a State of Tennessee Voluntary Buyout Program (VBP) severance payment with regard to contracts with state agencies that participated in the VBP.

- a. The State will not contract with either a former state employee who received a VBP severance payment or an entity in which a former state employee who received a VBP severance payment or the spouse of such an individual holds a controlling financial interest.
- b. The State may contract with an entity with which a former state employee who received a VBP severance payment is an employee or an independent contractor. Notwithstanding the foregoing, the Contractor understands and agrees that there may be unique business circumstances under which a return to work by a former state employee who received a VBP severance payment as an employee or an independent contractor of a State contractor would not be appropriate, and in such cases the State may refuse Contractor personnel. Inasmuch, it shall be the responsibility of the State to review Contractor personnel to identify any such issues.
- c. With reference to either subsection a. or b. above, a contractor may submit a written request for a waiver of the VBP restrictions regarding a former state employee and a contract with a state agency that participated in the VBP. Any such request must be submitted to the State in the form of the *VBP Contracting Restriction Waiver Request* format available from the State and the Internet at: www.state.tn.us/finance/rds/ocr/waiver.html. The determination on such a request shall be at the sole discretion of the head of the state agency that is a Party to this Contract, the Commissioner of Finance and Administration, and the Commissioner of Human Resources.

Amendment 19 (cont.)

All of the provisions of the original Contract not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective March 1, 2009.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

VOLUNTEER STATE HEALTH PLAN, INC.

BY: M D Goetz Jr / sc
M. D. Goetz, Jr.
Commissioner

BY: Sonya Nelson
Sonya Nelson
President and Chief Executive Officer

DATE: 2/25/09

DATE: Pres. + CEO

APPROVED BY:

APPROVED BY:

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

**STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY**

BY: M.D. Goetz Jr / KS
M. D. Goetz, Jr.
Commissioner

BY: Justin P. Wilton / MKO
~~John G. Morgan~~ Justin P. Wilton
Comptroller

DATE: 3/5/09

DATE: 3/10/09

CONTRACT SUMMARY SHEET

RFS Number:	318.66-026	Contract Number:	FA-02-14632-18
State Agency:	Department of Finance and Administration	Division:	Bureau of TennCare

Contractor	Contract Identification Number
VSHP (TennCare Select)	<input type="checkbox"/> V- <input type="checkbox"/> C-

Service Description

Managed Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medicaid Population

Contract Begin Date	Contract End Date
7/1/2001	6/30/2009

Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66	4A2	134	11	<input type="checkbox"/> STARS		
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)	
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$ 18,599,868.48	
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$ 33,079,942.80	
2004	\$ 25,125,990.72	\$ 38,364,165.90			\$ 63,490,156.62	
2005	\$ 58,007,447.00	\$ 58,007,447.00			\$ 116,014,894.00	
2006	\$87,748,111.00	\$87,748,111.00			\$175,496,222.00	
2007	\$87,748,111.00	\$87,748,111.00			\$175,496,222.00	
2008	\$72,610,000.00	\$127,390,000.00			\$200,000,000.00	
2009	\$72,610,000.00	\$127,390,000.00			\$200,000,000.00	
Total:	\$ 426,390,720.35	\$ 555,786,585.55			\$982,177,305.90	

CFDA#	93.778 Title XIX Dept. of Health & Human Svcs.	Check the box ONLY if the answer is YES:
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State Fiscal Contract		
Name:	Scott Pierce	Is the Contractor a SUBRECIPIENT? (per OMB A-133)
Address:	310 Great Circle Road	Is the Contractor a Vendor? (per OMB A-133)
Phone:	Nashville, TN (615)507-6415	Is the Fiscal Year Funding STRICTLY LIMITED?
Procuring Agency Budget Officer Approval Signature		Is the Contractor on STARS?
Scott Pierce		Is the Contractor's FORM W-9 ATTACHED?
		Is the Contractor's Form W-9 Filed with Accounts?

COMPLETE FOR ALL AMENDMENTS (only)		
	Base Contract & Prior Amendments	This Amendment ONLY
CONTRACT END DATE:	6/30/2008	6/30/2009
FY: 2002	\$ 18,599,868.48	
FY: 2003	\$ 33,079,942.80	
FY: 2004	\$ 63,490,156.62	
FY: 2005	\$116,014,894.00	
FY: 2006	\$175,496,222.00	
FY: 2007	\$175,151,878.00	
FY: 2008	\$200,000,000.00	
FY: 2009		\$200,000,000.00
Total:	\$782,177,305.90	\$200,000,000.00

Funding Certification

Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.

RECEIVED

MAY 23 AM 9:58

COMPTROLLER'S OFFICE
OFFICE OF
MANAGEMENT SERVICES

AMENDMENT NUMBER 18

**AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.**

CONTRACT NUMBER: FA-02-14632-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as follows:

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. Section 1-1 shall be amended by deleting and replacing the CONTRACTOR's contact information as follows:

Sonya Nelson
President and Chief Executive Officer
Volunteer State Health Plan, Inc.
801 Pine Street
Chattanooga, TN 37402-2555

2. The Non-Emergency Transportation Benefit description in Section 2-3.1.2 shall be deleted in its entirety and substituted with the following:

Non-Emergency Medical Transportation (including Non- Emergency Ambulance Transportation)	Covered non-emergency medical transportation (NEMT) services are necessary non-emergency transportation services provided to convey members to and from TennCare covered services (see definition in Exhibit A to Attachment XIII) other than behavioral health services covered by the BHO. Non emergency transportation services shall be provided in accordance with federal law and the Bureau of TennCare's rules and policies and procedures. TennCare covered services (see definition in Exhibit A to Attachment XIII) include services (other than behavioral health services covered by the BHO) provided to a member by a non-contract or non-TennCare provider if (a) the service is covered by Tennessee's Medicaid State Plan or Section 1115 demonstration waiver, (b) the provider could be a TennCare provider for that service, and (c) the service is covered by a third party resource (see definition in Section 1-3 of the Agreement). If a member requires assistance, an escort (as defined in TennCare rules and regulations) may accompany the member; however, only one (1) escort is allowed per member (see TennCare rules and regulations). Except for fixed route and commercial carrier transport, the CONTRACTOR shall not make separate or additional payment to a NEMT provider for
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	<p>an escort.</p> <p>Covered NEMT services include having an accompanying adult ride with a member if the member is under age eighteen (18). Except for fixed route and commercial carrier transport, the CONTRACTOR shall not make separate or additional payment to a NEMT provider for an adult accompanying a member under age eighteen (18).</p> <p>The CONTRACTOR is not responsible for providing NEMT to any service that is being provided to the member through a HCBS waiver.</p> <p>Mileage reimbursement, car rental fees, or other reimbursement for use of a private automobile (as defined in Exhibit A to Attachment XIII) is not a covered NEMT service.</p> <p>If the CONTRACTOR is unable to meet the access standards included in this Agreement (see Section 2-4.1) for a member, transportation shall be provided.</p> <p>If the member is a child, transportation shall be provided in accordance with TENNderCare requirements (see Section 2-3.17.1.2).</p> <p>Failure to comply with the provisions of this Section may result in liquidated damages.</p>
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3. Section 1-3(86) relative to the definition of "Community Health Record" shall be deleted in its entirety.
4. Section 1-3(88) relative to the definition of "Contributing Data to the Community Health Record" shall be deleted in its entirety.
5. Section 2-3.3 shall be deleted and replaced as follows:

2.3.3 Medical Necessity Determination

The CONTRACTOR shall not impose any service limitations that are more restrictive than those described herein; however, this provision shall not limit the CONTRACTOR's ability to establish procedures for the determination of medical necessity or to use medically appropriate, cost effective alternative services, in accordance with Section 2-3.10.. The determination of medical necessity shall be made on a case by case basis. Except for benefit limits as may be described in Section 2-3.1, the CONTRACTOR shall not employ, and shall not permit others acting on their behalf to employ utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each TennCare enrollee and his/her medical history. The CONTRACTOR shall have the ability to place tentative limits on a service; however, such tentative limits placed by the CONTRACTOR shall be exceeded when medically necessary based on a patient's individual characteristics. The CONTRACTOR shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. The CONTRACTOR may deny services that are non-covered except as otherwise required by EPSDT or unless otherwise directed to provide by TENNCARE and/or an administrative law judge. Any procedures used to determine medical necessity shall be consistent with the definition of medical necessity as described in this Contract.

All medically necessary services shall be covered for enrollees under 21 years of age in accordance with EPSDT requirements, including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989. Effective upon receipt of written notification from TENNCARE, the CONTRACTOR is not required to provide services in accordance with EPSDT requirements to TennCare Standard enrollees under the age of 21.

6. Section 2-3.10 shall be deleted and replaced in its entirety.

2-3.10. Use of Cost-Effective Alternative Services

The CONTRACTOR shall be allowed to use alternative services, whether listed as covered or non-covered or omitted in Section 2-3.1 of this Agreement when the use of such alternative services is medically appropriate and is cost-effective. This may include, for example, use of nursing facilities as step down alternatives to acute care hospitalization or hotel accommodations for persons on outpatient radiation therapy to avoid the rigors of daily transportation. The CONTRACTOR shall comply with TennCare policies and procedures. As provided in the applicable TennCare policies and procedures, services not listed in the TennCare policies and procedures must be prior approved in writing by TENNCARE. The Medical Fund Target described elsewhere in this Agreement shall not be increased or decreased because of the use of alternative services. The CONTRACTOR shall maintain documentation that demonstrates the cost effectiveness of any non-covered services that are provided to TennCare enrollees and for which the CONTRACTOR seeks reimbursement from the state. A report summarizing all such documentation for the preceding year shall be submitted by the CONTRACTOR in accordance with Section 2-10.5.4.

7. Section 2-3.17.1.2 shall be deleted in its entirety and substituted with the following:

2-3.17.1.2 Transportation assistance for a child and for the child's escort or accompanying adult, including related travel expenses, cost of meals, and lodging en route to and from TennCare covered services (other than behavioral health services covered by the BHO). The requirement to provide the cost of meals shall not be interpreted to mean that a member (or the child's escort or accompanying adult) can request meals while in transport to and from care. Reimbursement for meals and lodging shall only be provided when transportation for a TennCare covered service cannot be completed in one (1) day and would require an overnight stay.

The CONTRACTOR shall offer transportation and scheduling assistance to all children under age 21 referred for an assessment who do not have access to transportation. This may be accomplished through various means of communication to enrollees, including but not limited to, member handbooks, EPSDT outreach notifications, etc.

8. Section 2-4.1.2.d shall be deleted in its entirety.
9. Section 2-4.7.5 shall be deleted and replaced as follows:

2-4.7.5 Services Ordered by Medicare Providers for Dual Eligibles

Generally, when a TennCare enrollee is dually eligible for Medicare and Medicaid and requires services that are covered by the plan but are not covered by Medicare, and the services are ordered by a Medicare provider who does not participate in the CONTRACTOR's plan, the CONTRACTOR must pay for the ordered service if it is provided by a contract provider. However, if all of the following criteria are met, the CONTRACTOR may require that the ordering physician be a contracted provider:

- (1) The ordered services requires prior authorization; and

- (2) Dually eligible enrollees have been clearly informed of the contracted provider requirement and instructed in how to obtain assistance identifying and making an appointment with a contract provider; and
- (3) The CONTRACTOR assists the enrollee in obtaining a timely appointment with a contract provider upon request of the enrollee or upon receipt of an order from a non-contract provider.

Reimbursement shall be at the same rate that would have been paid had the service been ordered by a contract provider. The CONTRACTOR shall not be liable for the cost of non-covered services or services which are not medically necessary or the cost of services ordered and obtained from non-contract providers.

In order to assure the TennCare/Medicare (dual population) enrollees assigned to TennCare MCOs continue to receive pharmacy services without interruption during the carve-out of their pharmacy benefits, each MCO is required to execute whatever measures are necessary with their subcontractor - pharmacy benefits manager (PBM) - so that a text message is sent to each dispensing pharmacy when a claim for a TennCare/Medicare enrollee is submitted to an MCO's PBM in error. The text message sent to the pharmacy must direct the pharmacy to submit the claim to the point-of-service, online pharmacy claims processor under contract to the TennCare Bureau to process pharmacy claims for TennCare/Medicare enrollees.

10. Section 2-7.1.g. shall be deleted and replaced in its entirety.

g. Disease Management for Obesity. In addition to the aforementioned disease management requirements, the CONTRACTOR shall have a DM program for obesity that is provided as a cost effective alternative service (see Section 2-3.h). The CONTRACTOR may fulfill this requirement by entering into a provider agreement with Weight Watchers and then referring/authorizing eligible obese and overweight members to participate in a Weight Watchers program. If the CONTRACTOR identifies another weight management program as the cost effective alternative service, the CONTRACTOR shall include a narrative of the program (including target population and description of services) as part of its quarterly disease management report (see Section 2-10.13.7) applicable to the quarter in which the program was implemented.

11. Section 2-9.2 shall be deleted and replaced as follows:

2-9.2 Performance Benchmarks

The following performance indicators related to administration and management have been identified for on-going monitoring. The CONTRACTOR's failure to meet these benchmarks or demonstrate improvement toward benchmark levels of performance shall result in the CONTRACTOR being required to implement a corrective action plan as described in Section 2-16.

Performance Indicator	Data Sources	Measure	Units	Benchmark
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Performance Indicator	Data Sources	Measure	Target	Benchmark
Volume of Provider Complaints	Monthly Activity Report	# of provider complaints received relative to number of providers (Complaint is defined as an issue a provider presents to the managed care organization, either in written or oral form, which is subject to resolution by the MCO).	0 percent	MCO specific benchmark. 10% reduction over prior year.
Claims Payment Accuracy and Timeliness	<p>Claims and Encounter Data</p> <p>Note: Self-reported based on internal audit conducted on statistically valid random sample on a quarterly basis.</p> <p>Audit procedures and sample methodology to be submitted to TDCI for review and approval with first quarter's report.</p>	<p>1. Accuracy: Number of claims processed for payment and paid accurately upon initial submission divided by the total number of claims.</p> <p>2. Timeliness of Clean Claims Processing: Number of clean claims processed within thirty (30) calendar days of receipt divided by the total number of clean claims received (for calculation date of receipt counts as day zero).</p> <p>Timeliness of Clean and Unclean Claims Processing: Number of claims processed and, if appropriate, paid within sixty (60) days of receipt divided by the number of all claims processed (for calculation date of receipt counts as day zero)</p> <p>Processing To be measured and reported monthly</p>	100 percent	<p>Accuracy: 97% of claims are processed or paid accurately upon initial submission</p> <p>Timeliness of Clean Claims Processing: 90% of clean claims are paid within 30 days of receipt of these claims.</p> <p>Timeliness of Clean and Unclean Claims Processing: 99.5% of all claims within sixty (60) days of receipt.</p>

Performance Indicator	Data Sources	Measure	Target	Benchmark
Call Abandonment rate and call answer timeliness for Utilization Management line.	ACD Line Productivity Reports for calls where the provider/staff called directly into the UM call center or selected a UM call center option and was put in the call queue.	<p>1. Call Abandonment Rate: The number of calls abandoned by the caller or the system before being answered by a live voice divided by the number of calls received by the MCO UM call center (during UM open hours of operation) during the measurement period.</p> <p>2. Call Answer Timeliness: The number of calls answered by a live voice within thirty (30) seconds, divided by the number of calls received by the CONTRACTOR's UM call center(s) (during UM call center open hours of operation) during the measurement period.</p>	Same as Benchmark	<p>Call Abandonment rate: Less than 5% of calls abandoned</p> <p>85% of all Calls answered by a live voice within thirty (30) seconds</p>
Call Abandonment rate and call answer timeliness for Member Services line	<p>ACD Line Productivity Reports for calls where the member called directly into member services or selected a member services option and was put in the call queue.</p> <p>Refer to NCQA HEDIS Technical Specifications for further clarification and changes.</p>	<p>1. Call Abandonment Rate: The number of calls abandoned by the caller or the system before being answered by a live voice. Divided by the number of calls received by the MCO member services call center as (during member services open hours of operation) during the measurement period.</p> <p>2. Call Answer Timeliness: The number of calls answered by a live voice within thirty (30) seconds, divided by the number of calls received by the CONTRACTOR's member services call center(s) (during member services open hours of operation) during the measurement period.</p>	0 percent	<p>Call Abandonment rate: Less than 5% of calls abandoned</p> <p>85% of all Calls answered by a live voice within thirty (30) seconds or the prevailing benchmark established by NCQA</p>

Performance Indicator	Data Sources	Metric	Target	Benchmark
Provider Network Documentation	Provider Enrollment File and provider agreement signature pages	Providers listed on Provider Enrollment file with an "In Plan" indicator must have a signed agreement	Same as benchmark	100% of providers on the Provider Enrollment File with an "In Plan" indicator shall have a signed provider agreement with the CONTRACTOR
Specialist Provider Network	Provider Enrollment File	Executed contract is a signed agreement with a provider to participate in the Contractor's network as a contract provider	Same as benchmark	<p>1. Physician Specialists: Executed specialty physician contracts in all areas required by this Agreement for the following nine specialists: allergy; cardiology; dermatology; endocrinology; gastroenterology; general surgery; nephrology; neurology; neurosurgery; otolaryngology; ophthalmology; orthopedics; oncology/hematology; and urology.</p> <p>2. Essential Hospital Services: Executed contract with at least one (1) Tertiary Care Center for each essential hospital service</p> <p>3. Center of Excellence for People with AIDs: Executed contract with at least two (2) Center of Excellence for AIDs within the CONTRACTOR's approved Grand Region(s)</p>

Performance Indicator	Data Sources	Measure	Target	Benchmark
Provider Participation Accuracy	Provider Enrollment File	A statistically valid sample of participating providers on the most recent monthly provider enrollment file confirm that they are participating in the CONTRACTOR's network	Same as Benchmark	At least 90% of listed providers confirm participation in the CONTRACTOR's network
Provider Information Accuracy	Provider Enrollment File	Data for no more than 10% of a statistically valid sample of participating providers on the most recent monthly provider enrollment is incorrect for each element as determined by TENNCARE	Same as Benchmark	Data for no more than 10% of listed providers is incorrect for each data element
Distance from Provider to Member	Provider Enrollment File	Time and travel distance as measured by GeoAccess	Same as Benchmark	Provider network includes sufficient numbers and geographical disbursement of providers in order to satisfy the access standards described in this Agreement including Attachments III and IV
Encounter Data Submissions	TennCare Edit Reports	Error Threshold Exceeded	Same as Benchmark	Less than 2% of file contains errors by submission due date
EPSDT Screening and Medical Record Documentation	MCO Encounter Data and Medical Chart Audit	The EPSDT screening ratio, calculated in accordance with specifications for the CMS-416 report, multiplied by the percentage of the required seven (7) screening components that are completed as determined through a statistically valid sample of medical records of the MCO's enrollees	Same as Benchmark	Demonstrated active pursuit and completion of activities designed to increase the CONTRACTOR's EPSDT screening ratio and the percentage of screens that are completed and include all seven (7) required screening components

Performance Indicator	Data Sources	Measure	Priority	Benchmark
CAHPS Survey Report	Annual Member Satisfaction Survey	A set of standardized surveys that measure patient satisfaction with experience of care	Same as Benchmark	Report of annual CAHPS survey results due by June 15th. Rating of the Healthplan: CONTRACTOR must meet or exceed Medicaid National average as reported in Quality Compass. 2004 rating was 69.9%.
HEDIS Report	Annual HEDIS measurement as required by NCQA	A set of standardized performance measures designed to allow reliable comparison of the performance of managed health care plans	Same as Benchmark	Report of audited HEDIS data due by June 15th
Provider Satisfaction Survey Report	Annual Provider Satisfaction Survey	Survey of provider satisfaction with Prior Authorization process	Same as Benchmark	Report due by June 15th
NCQA Accreditation Report	NCQA	Final Accreditation Report in its entirety from NCQA's initial survey and annual revised accreditation status	Same as Benchmark	Accreditation

12. Section 2-9 shall be amended by adding a new 2-9.16.

2-9.16 Reimbursement for All Covered Services

2-9.16.1 Except as provided in Sections 2-9.16.2 and 2-9.16.3 below, the CONTRACTOR shall not reimburse providers based on a percentage of billed charges.

2-9.16.2 The CONTRACTOR may, at its discretion, pay a percentage of billed charges for covered services for which there is no Medicare reimbursement methodology.

2-9.16.3 As part of a stop-loss arrangement with a provider, the CONTRACTOR may, at its discretion, pay the provider a percentage of billed charges for claims that exceed the applicable stop-loss threshold.

13. Section 2-10.3.3 shall be deleted in its entirety and "Left Blank Intentionally".

14. Section 2-10.5 shall be amended by adding a new item 4 which shall read as follows:

4. Cost Effective Service Reporting

The CONTRACTOR shall maintain documentation that demonstrates the cost effectiveness of any non-covered services that are provided to TennCare enrollees and for which the CONTRACTOR seeks reimbursement from the state. A report summarizing all such documentation for the preceding year shall be submitted by the CONTRACTOR no later than sixty (60) calendar days after the end of each state fiscal year.

15. Section 2-10.7.3 entitled "Community Health Record for TennCare Enrollees (Electronic Medical Record)" shall be deleted in its entirety.
16. Section 2-10.13.2 shall be deleted and replaced in its entirety.

2-10.13.2. Quality Improvement Activity Forms

In accordance with Section 2-9.j.2., the CONTRACTOR shall electronically submit Quality Improvement Activity Forms as required by NCQA. These forms are available at www.NCQA.org

17. Section 2-18 shall be amended by adding a new 2-18.y and renumbering existing subparts accordingly, including any references thereto.
 - 2.18.y. As a condition of reimbursement for global procedure codes for obstetric care, the provider shall submit utilization or encounter data as specified by the CONTRACTOR in a timely manner to support the individual services provided;
18. Section 2-28 entitled "Community Health Record" shall be deleted in its entirety.
19. Section 5-1(i) relative to the reporting requirements and administrative services fee for the Community Health Record shall be deleted in its entirety.
20. The last paragraph of Section 5-1(j) shall be amended by deleting and replacing "Adolescent Immunizations (combo2)" with "Adolescent Well-Care Visits".
21. Item A.2 in Section 6-8.2.2 shall be deleted in its entirety and substituted with the following:

A.2	Failure to comply with licensure requirements in Section 2-9.4 and Attachment XIII of this Agreement		\$5,000 per calendar day that staff/provider/driver/agent/subcontractor is not licensed as required by applicable state or local law plus the amount paid to the staff/provider/driver/agent/subcontractor during that period
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22. Item B.24 in Section 6-8.2.2. shall be deleted in their entirety and substituted with the following:

B.24	Failure to maintain provider agreements in accordance with Section 2-18 and Attachment XIII of this Agreement		\$5000 per provider agreement found to be non-compliant with the requirements outlined in this Agreement
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23. Section 6-8.2.2 shall be amended by adding a new C.5 which shall read as follows:

C.5	Failure to submit a Provider Enrollment File that meets TENNCARE's specifications		\$250 per day after the due date that the Provider Enrollment File fails to meet TENNCARE's specifications
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24. Section 6-28 shall be amended by deleting and replacing June 30, 2008 with June 30, 2009.

6-28 Contract Term of The Agreement

This Agreement and its incorporated attachments, if any, as well as all Amendments to this Agreement, contain all of the terms and conditions agreed upon by the parties, and when executed by all parties, supersedes any prior agreements. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall be in effect from July 1, 2001, subject to approval by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The term of this Agreement shall expire on June 30, 2009. At the mutual agreement of TennCare and the CONTRACTOR, this CONTRACT shall be renewable for an additional twelve month period.

Notwithstanding any provision herein to the contrary, the State may terminate this Agreement if the waiver governing TennCare is terminated. The documents referenced in the Agreement are on file with the CONTRACTOR and with TENNCARE and the CONTRACTOR is aware of their content. No other agreement, oral or otherwise regarding the subject matter of this Agreement, shall be deemed to exist or to bind any of the parties hereto.

25. Section 7-3(l) relative to the approval process for the Community Health Record shall be deleted in its entirety.
26. Attachment I shall be amended by adding "N. Policies and procedures for delivering NEMT services, including an operating procedures manual, as provided in Section A.1 of Attachment XIII" after item M in Section I.
27. A new Attachment XIII shall be inserted to read as follows:

**ATTACHMENT XIII
NEMT REQUIREMENTS**

A.1 GENERAL

- A.1.1 The CONTRACTOR, in its delivery of NEMT services, shall comply with all of the requirements in this Attachment XIII. The requirements in this Attachment are in addition to, not instead of, requirements found elsewhere in the Agreement.
- A.1.2 The CONTRACTOR shall develop written policies and procedures that describe how the CONTRACTOR, in the delivery of NEMT services, shall comply with the requirements of the Agreement, including this Attachment. These policies and procedures must be prior approved in writing by TENNCARE. As part of its policies and procedures the CONTRACTOR shall develop an operating procedures manual detailing procedures for meeting, at a minimum, requirements regarding the following:
- A.1.2.1 Requesting NEMT services (see Section A.3 of this Attachment);
 - A.1.2.2 Approving NEMT services (see Section A.4 of this Attachment); and
 - A.1.2.3 Scheduling, assigning and dispatching trips (see Section A.5 of this Attachment).

A.2 NEMT IMPLEMENTATION WORK PLAN AND READINESS REVIEW

- A.2.1 The CONTRACTOR shall implement the NEMT requirements of the Agreement, including this Attachment XIII, in two phases. Phase One shall include the requirements specified by TENNCARE, which shall include but not be limited to vehicle and driver standards in Section A.7 and Section A.8 of this Attachment XIII. Phase Two shall include all NEMT requirements of the Agreement that are not included in Phase One.
- A.2.2 By no later than May 1, 2008 the CONTRACTOR shall submit to TENNCARE for prior written approval an implementation work plan that details all of the tasks required to successfully implement all of the NEMT requirements of the Agreement, including both Phase One and Phase Two requirements. By September 1, 2008, the CONTRACTOR shall have fully implemented the implementation work plan for Phase One, and the CONTRACTOR may be subject to liquidated damages for failure to comply with the applicable provisions herein. The CONTRACTOR shall have fully implemented all NEMT requirements of the Agreement by the date specified by TENNCARE, which shall be no earlier than September 1, 2008, and at that time the CONTRACTOR may be subject to liquidated damages for failure to comply with any of the provisions herein.
- A.2.3 Prior to implementation of any of the NEMT requirements in this Attachment, as determined by TENNCARE, the CONTRACTOR shall demonstrate to TENNCARE's satisfaction that the CONTRACTOR is able to meet the NEMT requirements specified by TENNCARE.
- A.2.4 The CONTRACTOR shall cooperate in "readiness reviews" conducted by TENNCARE to review the CONTRACTOR's readiness to implement any or all of the NEMT requirements of the Agreement. These reviews may include, but are not limited to, desk and on-site review of documents provided by the CONTRACTOR, a walk-through of the CONTRACTOR's operations, system demonstrations (including systems connectivity testing), and interviews with CONTRACTOR's staff .
- A.2.5 Based on the results of the review activities, TENNCARE will issue a letter of findings and, if needed, will request a corrective action plan from the CONTRACTOR.

A.3 REQUESTING NEMT SERVICES

- A.3.1 Members or their representatives shall be allowed to make requests for NEMT services on behalf of members. For DCS enrollees (as defined in Exhibit A of this Attachment), representatives include the member's DCS liaison, foster parent, adoptive parent, or provider.
- A.3.2 Requests for NEMT services should be made at least seventy-two (72) hours before the NEMT service is needed. However, this timeframe does not apply to urgent trips (see Section A.5.7 of this Attachment), scheduling changes initiated by the provider, and follow-up appointments when the timeframe does not allow advance scheduling. In addition, the CONTRACTOR shall accommodate requests for NEMT services that are made within the following timeframes: three (3) hours before the NEMT service is needed when the pick-up address is in an urban area and four (4) hours before the NEMT service is needed when the pick-up address is in a non-urban area. The CONTRACTOR shall provide additional education to members who fail to request transportation seventy-two (72) hours before the NEMT service is needed (see Section A.10 of this Attachment).
- A.3.3 The CONTRACTOR shall not have a time limit for scheduling transportation for future appointments. For example, if a member calls to schedule transportation to an appointment that is scheduled in two (2) months, the CONTRACTOR shall arrange for that transportation and shall not require the member to call back at a later time.

A.4 APPROVING NEMT SERVICES

A.4.1 General

- A.4.1.1 Transportation for a minor child shall not be denied pursuant to any policy that poses a blanket restriction due to member's age or lack of accompanying adult. Any decision to deny transportation of a minor child due to a member's age or lack of an accompanying adult shall be made on a case-by-case basis and shall be based on the individual facts surrounding the request and State of Tennessee law. Tennessee recognizes the "mature minor exception" to permission for medical treatment. The age of consent for children with mental illness is sixteen (16) (see TCA 33-8-202).
- A.4.1.2 As part of the approval process, the CONTRACTOR shall:
 - A.4.1.2.1 Collect relevant information from the caller and enter it into the CONTRACTOR's system (see Section A.5.10 of this Attachment);
 - A.4.1.2.2 Verify the member's eligibility for NEMT services;
 - A.4.1.2.3 Determine the appropriate mode of transportation for the member;
 - A.4.1.2.4 Determine the appropriate level of service for the member;
 - A.4.1.2.5 Approve or deny the request; and
 - A.4.1.2.6 Enter the appropriate information into the CONTRACTOR's system (see Section A.5.10 of this Attachment).

Amendment 18 (cont.)

A.4.2 Verifying Eligibility for NEMT Services

- A.4.2.1 The CONTRACTOR shall screen all requests for NEMT services to confirm each of the following items:
 - A.4.2.1.1 That the person for whom the transportation is being requested is a TennCare enrollee and enrolled in the CONTRACTOR's MCO;
 - A.4.2.1.2 That the service for which NEMT service is requested is a TennCare covered service (as defined in Exhibit A of this Attachment); and
 - A.4.2.1.3 That the transportation is a covered NEMT service (see Section 2-3.1.2 of the Agreement).

A.4.3 Determining the Appropriate Mode of Transportation

A.4.3.1 General

- A.4.3.1.1 If the criteria in Section A.4.2 of this Attachment are met, the CONTRACTOR shall determine what mode of transportation is appropriate to meet the needs of the member. The modes of transportation that shall be covered by the CONTRACTOR include, but are not limited to: fixed route, multi-passenger van, wheelchair van, invalid vehicle, and ambulance.
- A.4.3.1.2 In order to determine the appropriate mode of transportation, the CONTRACTOR shall:
 - A.4.3.1.2.1 Determine whether the member is ambulatory and the member's current level of mobility and functional independence;
 - A.4.3.1.2.2 Determine whether the member will be accompanied by an escort, and, if so, whether the member requires assistance and whether the escort meets the requirements for an escort (see TennCare rules and regulations);
 - A.4.3.1.2.3 Determine whether a member is under the age of eighteen (18) and will be accompanied by an adult; and
 - A.4.3.1.2.4 Assess any special conditions or needs of the member, including physical or mental disabilities.

A.4.3.2 Fixed Route

- A.4.3.2.1 The CONTRACTOR shall utilize fixed route transportation whenever available and appropriate to meet the needs of the member.
- A.4.3.2.2 The CONTRACTOR shall be familiar with schedules of fixed route transportation in communities where it is available and where it becomes available during the term of the Agreement.
- A.4.3.2.3 The CONTRACTOR shall distribute and/or arrange for the distribution of fixed route tickets, tokens or passes to members for whom fixed route transportation is available and appropriate. The CONTRACTOR shall have controls in place to track the distribution of tickets/tokens/passes. The CONTRACTOR shall use best efforts that tickets/tokens/passes are used appropriately.
- A.4.3.2.4 The CONTRACTOR shall consider the following when determining whether fixed route transportation is available and appropriate for a member:

Amendment 18 (cont.)

- A.4.3.2.4.1 The furthest distance a member shall be required to travel to or from a fixed route transportation stop is one-quarter (1/4th) of a mile;
 - A.4.3.2.4.2 The member shall not be required to change buses/trolleys more than once each leg of the trip;
 - A.4.3.2.4.3 Using fixed route transportation shall not increase travel time more than sixty (60) minutes as compared to transportation directly from the pick-up location to the drop-off destination;
 - A.4.3.2.4.4 The fixed route transportation schedule shall allow the member to arrive at the destination no more than sixty (60) minutes prior to the scheduled appointment time and shall be flexible on the return so that the member does not have to wait at the pick-up location more than sixty (60) minutes after the estimated time the appointment will end;
 - A.4.3.2.4.5 Whether fixed route transportation is appropriate based on the member's physical or mental disabilities; and
 - A.4.3.2.4.6 Whether using fixed route for the requested trip is appropriate considering the accessibility of the stops and the safety in accessing the stops.
- A.4.3.2.5 Fixed route shall not be appropriate for a member whose physician states in writing that the member cannot use fixed route transportation.

A.4.3.3 Ambulance

The CONTRACTOR's policies and procedures regarding the appropriateness of using an ambulance to provide covered NEMT services shall be based on Medicare's medical necessity requirements (see, e.g., 42 CFR 410.40 and Medicare Benefit Policy Manual, Chapter 10 - Ambulance Services).

A.4.4 **Determining Level of Service**

- A.4.4.1 The CONTRACTOR shall assess the member's needs to determine whether the member requires curb-to-curb, door-to-door, or hand-to-hand service (as these terms are defined in Exhibit A of this Attachment).
- A.4.4.2 The CONTRACTOR may require a medical certification statement from the member's provider in order to approve door-to-door or hand-to-hand service. Medical certification shall be completed within the timeframes specified in Section A.5.1.3 of this Attachment.
- A.4.4.3 The CONTRACTOR shall ensure that members receive the appropriate level of service.
- A.4.4.4 Failure to comply with requirements regarding level of service may result in liquidated damages as provided in Section 6-8.2 of the Agreement, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

A.4.5 **Standing Orders**

- A.4.5.1 Except as provided in this Section A.4.5, the approval of Standing Orders by the CONTRACTOR shall be consistent with the requirements in Sections A.4.1 through A.4.4.
- A.4.5.2 In order to approve a Standing Order (as defined in Exhibit A of this Attachment), the CONTRACTOR shall, at a minimum, call the provider to verify the series of appointments. The

Amendment 18 (cont.)

CONTRACTOR may, at its discretion, require that the member's provider certify the series of appointments in writing.

- A.4.5.3 The CONTRACTOR shall approve Standing Orders consistent with the series of appointments. For example, if the member has a series of appointments over six (6) months, the CONTRACTOR shall approve transportation for each trip, including all legs of the trip, for the six (6) months. However, the CONTRACTOR shall verify the member's eligibility prior to each pick-up. The CONTRACTOR may verify additional information before each pick-up as necessary.

A.4.6 Validating Requests

- A.4.6.1 The CONTRACTOR may conduct random pre-transportation validation checks prior to approving the request in order to prevent fraud and abuse.
- A.4.6.2 The CONTRACTOR may verify the need for an urgent trip with the provider prior to approving the trip.
- A.4.6.3 If requested by TENNCARE, the CONTRACTOR shall conduct pre-transportation validation checks of trips requested by specified members and/or to specific services or providers.
- A.4.6.4 All pre-transportation validation checks shall be conducted within the timeframes specified in Section A.5.1.3 of this Attachment.

A.5 SCHEDULING, ASSIGNING, AND DISPATCHING TRIPS

A.5.1 General

- A.5.1.1 The CONTRACTOR shall ensure that covered NEMT services are available twenty-four (24) hours a day, three hundred and sixty-five (365) days a year.
- A.5.1.2 After approving a NEMT service to be provided by a NEMT provider (i.e., not fixed route), the CONTRACTOR shall schedule and assign the trip to an appropriate NEMT provider.
- A.5.1.3 The CONTRACTOR shall approve and schedule or deny a request for transportation (including all legs of the trip) within twenty-four (24) hours of receiving the request. This timeframe shall be reduced as necessary to ensure the member arrives in time for his/her appointment. Failure to comply with this requirement may result in liquidated damages as provided in Section 6-8.2 of the Agreement, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.
- A.5.1.4 The CONTRACTOR shall ensure that trips are dispatched appropriately and meet the requirements of this Attachment. The dispatcher shall, at minimum, provide updated information to drivers, monitor drivers' locations, and resolve pick-up and delivery issues.

A.5.2 Multi-Passenger Transportation

- A.5.2.1 The CONTRACTOR may group enrollees and trips (or legs of trips) to promote efficiency and cost effectiveness. The CONTRACTOR may contact providers if necessary to coordinate multi-passenger transportation.
- A.5.2.2 For multi-passenger trips, the CONTRACTOR shall schedule each trip leg so that a member does not remain in the vehicle for more than one (1) hour minutes longer than the average travel time for direct transportation of that member.

A.5.3 Choice of NEMT Provider

Amendment 18 (cont.)

The CONTRACTOR is not required to use a particular NEMT provider or driver requested by the member. However, the CONTRACTOR may accommodate a member's request to have or not have a specific NEMT provider or driver.

A.5.4 Notifying Members of Arrangements

If possible, the CONTRACTOR shall inform the member of the transportation arrangements (see below) during the phone call requesting the NEMT service. Otherwise, the CONTRACTOR shall obtain the member's preferred method (e.g., phone call, email, fax) and time of contact, and the CONTRACTOR shall notify the member of the transportation arrangements (see below) as soon as the arrangements are in place (within the timeframe specified in Section A.5.1.3 of this Attachment) and prior to the date of the NEMT service. Information about transportation arrangements shall include but not be limited to the name and telephone number of the NEMT provider, the scheduled time and address of pick-up, and the name and address of the provider to whom the member seeks transport.

A.5.5 Notifying NEMT Providers

A.5.5.1 The CONTRACTOR shall provide a trip manifest to each NEMT provider no later than the NEMT provider's close of business the day before the date of the NEMT service.

A.5.5.2 The CONTRACTOR shall have the ability to send trip manifests to a NEMT provider by a facsimile device or secure electronic transmission, at the option of the NEMT provider. The CONTRACTOR shall ensure that provision of the trip manifest is in compliance with HIPAA requirements (see Section 2-4.10 of the Agreement). The CONTRACTOR shall have dedicated telephone lines available at all times for faxing purposes.

A.5.5.3 The trip manifests supplied to NEMT providers shall include all necessary information for the driver to perform the trip, including but not limited to the information listed in Exhibit B of this Attachment.

A.5.5.4 If the CONTRACTOR notifies a NEMT provider of a trip assignment after the timeframe specified in Section A.5.5.1, the CONTRACTOR shall also contact the NEMT provider by telephone or electronically to confirm that the trip will be accepted.

A.5.5.5 The CONTRACTOR shall communicate information regarding cancellations to the NEMT provider in an expeditious manner to avoid unnecessary trips.

A.5.6 Accommodating Scheduling Changes

A.5.6.1 The CONTRACTOR shall accommodate unforeseen schedule changes and shall timely assign the trip to another NEMT provider if necessary.

A.5.6.2 The CONTRACTOR shall ensure that neither NEMT providers nor drivers change the assigned pick-up time without permission from the CONTRACTOR.

Amendment 18 (cont.)

A.5.7 Urgent Trips

For urgent trips (as defined in Exhibit A of this Attachment), the CONTRACTOR shall contact an appropriate NEMT provider so that pick-up occurs within three (3) hours after the CONTRACTOR was notified when the pick-up address is in an urban area and four (4) hours after the CONTRACTOR was notified when the pick-up address is in a non-urban area. As provided in Section A.4.6.2 of this Agreement, the CONTRACTOR may verify the need for an urgent trip. Failure to comply with requirements regarding urgent trips may result in liquidated damages as provided in Section 6-8.2 of the Agreement, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

A.5.8 Adverse Weather Plan

The CONTRACTOR shall have policies and procedures for transporting members who need critical medical care, including but not limited to renal dialysis and chemotherapy, during adverse weather conditions. "Adverse weather conditions" includes, but is not limited to, extreme heat, extreme cold, flooding, tornado warnings and heavy snowfall. The policies and procedures shall include, at a minimum, staff training, methods of notification, and member education.

A.5.9 Contingency and Back-Up Plans

The CONTRACTOR shall have policies and procedures that describe contingency plans for unexpected peak transportation demands and back-up plans for instances when a vehicle is excessively late (more than twenty (20) minutes late) or is otherwise unavailable for service.

A.5.10 Approval and Scheduling System Features

- A.5.10.1 Each transportation request processed by the CONTRACTOR shall be assigned a unique number, shall contain all pertinent information about the request, and shall be available to NEMT Call Center staff. This information shall include, but not be limited to the following:
 - A.5.10.1.1 Verification of member's TennCare eligibility (e.g., member name, address, Medicaid ID number, and telephone number if available; eligibility start and end dates);
 - A.5.10.1.2 Determination that service is a TennCare covered service (e.g., category of service) (see Section A.4.2 of this Attachment);
 - A.5.10.1.3 Determination that the transportation is a covered NEMT service (see Section A.4.2 of this Attachment);
 - A.5.10.1.4 Determination of the appropriate mode of transportation (e.g., member's requested mode of transportation, member's special needs, availability and appropriateness of fixed route, the approved mode of transportation, justification for the approved mode of transportation);
 - A.5.10.1.5 Determination of the appropriate level of service (see Section A.4.4 of this Attachment);
 - A.5.10.1.6 Information regarding Standing Orders (if applicable) (see Section A.4.5 of this Attachment);
 - A.5.10.1.7 Information about whether the request was modified, approved or denied and how the member was notified;
 - A.5.10.1.8 Information about approved and scheduled transportation (e.g., elements required for the trip manifest; see Section A.5.5 of this Attachment);
 - A.5.10.1.9 Whether the request was validated;

Amendment 18 (cont.)

- A.5.10.1.10 Timeframes for the approval process (e.g., date and time of request, determination, scheduling, and notification of member); and
- A.5.10.1.11 If applicable, reason for trip cancellation.
- A.5.10.2 The CONTRACTOR's approval and scheduling systems shall be coded such that policies and procedures are applied consistently.
- A.5.10.3 Based on approval of previous NEMT services, the CONTRACTOR shall display members' permanent and temporary special needs, appropriate mode of transportation, and any other information necessary to ensure that appropriate transportation is approved and provided. All of this information shall be easily accessible by all NEMT Call Center staff.
- A.5.10.4 The CONTRACTOR's approval and scheduling systems shall also support the following:
 - A.5.10.4.1 A database of NEMT providers that includes information needed to determine trip assignments such as but not limited to: types of vehicles, number of vehicles by type, lift capacity of vehicles, and geographic coverage.
 - A.5.10.4.2 Automatic address validations, distance calculations and trip pricing, if applicable;
 - A.5.10.4.3 Ability to generate a trip manifest (see Section A.5.5 of this Attachment);
 - A.5.10.4.4 Standing Order and Single Trip (as defined in Exhibit A of this Attachment) reservation capability; and
 - A.5.10.4.5 Ability to determine if fixed route transportation is available and appropriate for the member.
- A.5.10.5 The CONTRACTOR's approval and scheduling system shall enable report and data submission as specified in the Agreement.

A.6 PICK-UP AND DELIVERY STANDARDS

- A.6.1 The CONTRACTOR shall ensure that NEMT providers arrive on time for scheduled pick-ups. The NEMT provider may arrive before the scheduled pick-up time, but the member shall not be required to board the vehicle prior to the scheduled pick-up time.
- A.6.2 The CONTRACTOR shall ensure that drivers make their presence known to the member and wait until at least five (5) minutes after the scheduled pick-up time. If the member is not present five (5) minutes after the scheduled pick-up time, the driver shall notify the dispatcher before departing from the pick-up location.
- A.6.3 The CONTRACTOR shall ensure that drivers provide, at a minimum, the approved level of service (curb-to-curb, door-to-door, or hand-to-hand).
- A.6.4 The CONTRACTOR shall ensure that members arrive at pre-arranged times for appointments and are picked up at pre-arranged times for the return leg of the trip. If there is no pre-arranged time for the return leg of the trip, the CONTRACTOR shall ensure that members are picked up within one (1) hour after notification.
- A.6.5 The CONTRACTOR shall ensure that the average waiting time for members for pick-up does not exceed ten (10) minutes past the scheduled pick-up time.
- A.6.6 The CONTRACTOR shall ensure that if the driver will not arrive on time to the pick-up location, the driver shall notify the dispatcher, and the member is contacted.

Amendment 18 (cont.)

- A.6.7 The CONTRACTOR shall ensure that if the driver will not arrive on time to an appointment, the driver shall notify the dispatcher, and the provider is contacted.
- A.6.8 The driver may refuse transportation when the member, his/her escort, or an accompanying adult (for a member under age eighteen (18)), according to a reasonable person's standards, is noticeably indisposed (disorderly conduct, indecent exposure, intoxicated), is armed (firearms), is in possession of illegal drugs, knives and/or other weapons, commits a criminal offense, or is in any other condition that may affect the safety of the driver or persons being transported. The CONTRACTOR shall ensure that if a driver refuses to transport a member the driver immediately notifies the dispatcher, and the dispatcher notifies the CONTRACTOR.
- A.6.9 The CONTRACTOR shall ensure that in the event of an incident or accident (see Section A.17.2 of this Attachment), the driver notifies the dispatcher immediately to report the incident or accident and that, if necessary, alternative transportation is arranged. The CONTRACTOR shall ensure that it is promptly notified of any incident or accident.
- A.6.10 Failure to comply with requirements regarding pick-up and delivery standards may result in liquidated damages as provided in Section 6-8.2 of the Agreement, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.
- A.7 VEHICLE STANDARDS**
- A.7.1 The CONTRACTOR shall ensure that all vehicles meet or exceed applicable federal, state, and local requirements and manufacturer's safety, mechanical, operating, and maintenance standards.
- A.7.2 The CONTRACTOR shall ensure that all vehicles comply with the vehicle requirements developed by the CONTRACTOR and prior approved in writing by TENNCARE, which at a minimum shall include compliance with applicable federal, state, and local requirements, the requirements in this Section, and the requirements in Exhibit C of this Attachment.
- A.7.3 The CONTRACTOR shall ensure that any vehicle used to cross a state's border complies with any and all applicable federal, state (State of Tennessee and/or other state), and local requirements.
- A.7.4 The CONTRACTOR shall ensure that each vehicle has a real-time link, telephone or two-way radio. Pagers are not acceptable as a substitute for this requirement.
- A.7.5 The CONTRACTOR shall ensure that all vehicles transporting members with disabilities comply with applicable requirements of the Americans with Disabilities Act (ADA), including the accessibility specifications for transportation vehicles.
- A.7.6 The CONTRACTOR shall ensure that, at minimum, all vehicles providing stretcher transport are owned and operated by an entity licensed by the Tennessee Department of Health (DOH) to provide invalid services, have an active valid permit issued by DOH as a ground invalid vehicle, and comply with DOH's requirements for ground invalid vehicles.
- A.7.7 The CONTRACTOR shall ensure that, except as otherwise permitted by State of Tennessee law, all ambulances are owned and operated by an entity licensed by DOH to provide ambulance services, have an active valid ambulance permit from DOH, and comply with DOH's requirements for ambulances. The CONTRACTOR shall also ensure that vehicles comply with any applicable local requirements.

Amendment 18 (cont.)

A.7.8 As required in Section A.17 of this Attachment, the CONTRACTOR shall inspect all vehicles (except fixed route, invalid vehicles, and ambulances) for compliance with applicable requirements and shall immediately remove any vehicle that is out of compliance.

A.7.9 Failure to comply with requirements regarding vehicle standards may result in liquidated damages as provided in Section 6-8.2 of the Agreement, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

A.8 TRAINING AND STANDARDS FOR DRIVERS

A.8.1 The CONTRACTOR shall ensure that all drivers receive appropriate training and meet applicable standards, as specified in this Section A.8. These requirements do not apply to drivers of fixed route transportation. Drivers of fixed route transportation shall comply with all rules, regulations, policies and procedures promulgated by the fixed route carrier, federal, state or local law.

A.8.2 Driver Training

A.8.2.1 The CONTRACTOR shall ensure that all drivers receive appropriate training prior to providing services under the Agreement and annually thereafter. This shall include a minimum of thirty-two (32) hours of training prior to providing services under the Agreement and a minimum of fifteen (15) hours of annual training.

A.8.2.2 Driver training shall include, at a minimum the following:

A.8.2.2.1 Customer service;

A.8.2.2.2 Passenger assistance;

A.8.2.2.3 Sensitivity training;

A.8.2.2.4 Mental health and substance abuse issues;

A.8.2.2.5 Title VI requirements (Civil Rights Act of 1964);

A.8.2.2.6 HIPAA privacy requirements;

A.8.2.2.7 ADA requirements;

A.8.2.2.8 Wheelchair securement/safety;

A.8.2.2.9 Seat belt usage and child restraints;

A.8.2.2.10 Handling and reporting accidents and incidents;

A.8.2.2.11 Emergency evacuation;

A.8.2.2.12 Daily vehicle inspection;

A.8.2.2.13 Defensive driving;

A.8.2.2.14 Risk management;

A.8.2.2.15 Communications;

Amendment 18 (cont.)

- A.8.2.2.16 Infection control;
- A.8.2.2.17 Annual road tests; and
- A.8.2.2.18 Reporting enrollee and provider fraud and abuse.

A.8.3 Standards for Drivers

- A.8.3.1 The CONTRACTOR shall ensure that all drivers comply with driver requirements developed by the CONTRACTOR and prior approved in writing by TENNCARE, which at a minimum shall include compliance with applicable federal, state, and local requirements, the requirements of this Section, and the requirements in Exhibit D of this Attachment.
- A.8.3.2 The CONTRACTOR shall ensure that all drivers are at least eighteen (18) years of age and have a Class D driver license with F (for hire endorsement) or commercial driver license (Class A, B, or C) issued by the State of Tennessee or the equivalent licensure issued by the driver's state of residence.
- A.8.3.3 The CONTRACTOR shall ensure that all drivers meet the State of Tennessee requirements regarding proof of financial responsibility and/or insurance.
- A.8.3.4 The CONTRACTOR shall ensure that any driver that crosses a state's border complies with any and all applicable federal, state (State of Tennessee and/or other state), and local requirements.
- A.8.3.5 The CONTRACTOR shall ensure that any personnel contracted by or employed by a NEMT provider to provide medical assistance to a member during a non-emergency ambulance trip is licensed by the State of Tennessee as an emergency medical technician (EMT) and complies with DOH requirements for EMTs.
- A.8.3.6 The CONTRACTOR shall ensure that all drivers pass a physical examination prior to providing services under the Agreement and have additional physical examinations as necessary to ensure that a driver is qualified to drive a passenger vehicle (e.g., if the driver has a heart attack or stroke). The physical examination shall be at least as extensive as the medical examination required by the United States Department of Transportation's Federal Motor Carrier Safety Administration (FMCSA) for commercial drivers.
- A.8.3.7 The CONTRACTOR shall ensure that all drivers pass a drug test prior to providing services under the Agreement. In addition, the CONTRACTOR shall ensure that an alcohol or drug test is conducted when a trained supervisor/employer of a driver has reasonable suspicion to believe that the driver has violated the CONTRACTOR's policies and procedures regarding use of alcohol and/or controlled substances, that random drug and alcohol tests are conducted, and that post accident drug and alcohol testing is conducted. The CONTRACTOR's policies and procedures for drug and alcohol testing shall, at a minimum, meet the FMCSA's alcohol and drug testing requirements for motor carriers.
- A.8.3.8 The CONTRACTOR shall ensure that criminal background checks pursuant to TCA 38-6-109 as well as national criminal background checks are conducted for all drivers prior to providing services under the Agreement and every five years thereafter. In addition, the CONTRACTOR shall ensure that random national criminal background checks are conducted. The CONTRACTOR shall develop a list of disqualifying criminal offenses, which at a minimum shall include the permanent and interim disqualifying criminal offenses that apply to applicants for a hazardous materials endorsement in Tennessee. Drivers that have been convicted or found not guilty by reason of insanity of any of the disqualifying criminal offenses shall not provide services under the Agreement.

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- A.8.3.9 The CONTRACTOR shall ensure that drivers immediately notify the NEMT provider and that the NEMT provider immediately notifies the CONTRACTOR if a driver is arrested for, charged with, or convicted of a criminal offense that would disqualify the driver under the Agreement.
- A.8.3.10 The CONTRACTOR shall ensure that no driver has been convicted of a criminal offense related to the driver's involvement with Medicare, Medicaid, or the federal Title XX services program (see Section 1128 of the Social Security Act and 42 CFR 455.106).
- A.8.3.11 The CONTRACTOR shall verify that drivers are not listed on the Tennessee Sexual Offender Registry or the equivalent registry in the state of the driver's residence prior to providing services under the Agreement and every five (5) years thereafter.
- A.8.3.12 The CONTRACTOR shall ensure that drivers pass a national driver license background check prior to providing services under the Agreement. This initial national driver license background check shall, at a minimum, show the following:
 - A.8.3.12.1 No conviction within the past ten (10) years for a major moving traffic violation such as driving while intoxicated or driving under the influence;
 - A.8.3.12.2 No conviction for reckless driving within the previous thirty-six (36) month period;
 - A.8.3.12.3 No conviction for leaving the scene of a personal injury or fatal accident within the previous thirty-six (36) months;
 - A.8.3.12.4 No conviction for a felony involving the use of an automobile within the previous thirty-six (36) months;
 - A.8.3.12.5 Conviction for no more than two (2) minor moving traffic violations such as speeding, failure to stop, or improper operation of a motor vehicle within the previous thirty-six (36) months;
 - A.8.3.12.6 Conviction for no more than one (1) at-fault accident resulting in personal injury or property damage within the previous thirty-six (36) months; and
 - A.8.3.12.7 Not have a combination of conviction for one (1) at-fault accident resulting in personal injury or property damage and conviction for one (1) unrelated minor moving traffic violation within the previous thirty-six (36) months.
- A.8.3.13 The CONTRACTOR shall ensure that drivers pass an annual national driver license background check. The annual check shall, at a minimum, show the following:
 - A.8.3.13.1 No conviction for a major moving traffic violation such as driving while intoxicated, driving under the influence, or reckless driving;
 - A.8.3.13.2 No conviction for leaving the scene of a personal injury or fatal accident;
 - A.8.3.13.3 No conviction for a felony involving the use of an automobile;
 - A.8.3.13.4 No more than two (2) convictions for minor moving traffic violations such as speeding, failure to stop, or improper operation of a motor vehicle;
 - A.8.3.13.5 No more than one (1) conviction for an at-fault accident resulting in personal injury or property damage; and

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- A.8.3.13.6 Not have a combination of one (1) conviction for an at-fault accident resulting in personal injury or property damage and one (1) conviction for an unrelated minor moving traffic violation.
- A.8.3.14 The CONTRACTOR shall require that drivers immediately notify the NEMT provider and that the NEMT provider immediately notifies the CONTRACTOR of any moving traffic violation or if a driver's license is suspended or revoked.
- A.8.3.15 The CONTRACTOR shall ensure that all ambulance drivers and invalid vehicle drivers comply with applicable DOH and local requirements.
- A.8.3.16 The CONTRACTOR shall require that drivers maintain daily transportation logs containing, at a minimum, the information listed in Exhibit E of this Attachment.
- A.8.3.17 As required in Section A.17 of this Attachment, the CONTRACTOR shall monitor drivers and immediately remove any driver that is out of compliance with applicable requirements.
- A.8.4 Failure to comply with requirements regarding driver training and driver standards may result in liquidated damages as provided in Section 6-8.2 of the Agreement, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.
- A.9 **NEMT CALL CENTER**
 - A.9.1 The CONTRACTOR shall maintain a NEMT Call Center to handle requests for NEMT services as well as questions, comments, and inquiries from members and their representatives, NEMT providers, and providers regarding NEMT services. The NEMT Call Center may use the same infrastructure as the CONTRACTOR's member services line, but the CONTRACTOR shall have a separate line or queue for NEMT calls, and NEMT Call Center staff shall be dedicated to NEMT calls.
 - A.9.2 The NEMT Call Center shall be appropriately staffed twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty-five (365) days a year to handle the call volume in compliance with the performance standards in Section A.9.6 of this Attachment. The CONTRACTOR shall ensure continuous availability of NEMT Call Center services.
 - A.9.3 Between the hours of 7:00 PM and 5:00 AM in the time zone applicable to the Grand Region served by the CONTRACTOR (for Middle, the applicable time zone shall be Central Time), the CONTRACTOR may use alternative arrangements to handle NEMT calls so long as there is no additional burden on the caller (e.g., the caller is not required to call a different number or to make a second call), and the call is promptly returned by the CONTRACTOR.
 - A.9.4 For hours that the CONTRACTOR is using alternative arrangements to handle NEMT calls (see Section A.9.3 of this Attachment), the CONTRACTOR shall provide an after hours message in, at a minimum, English and Spanish instructing the caller how to access the alternative arrangement (not requiring a second call) and also offering the caller the opportunity to leave a message.
 - A.9.5 The CONTRACTOR's NEMT Call Center system shall have the capability to identify and record the phone number of the caller if the caller's phone number is not blocked.
 - A.9.6 The CONTRACTOR shall have the capability of making outbound calls.
 - A.9.7 The CONTRACTOR shall maintain sufficient equipment and NEMT Call Center staff to handle anticipated call volume and ensure that calls are received and processed in accordance with the requirements of this Section A.9 and the following performance standards for each line or queue:
 - A.9.7.1 Blocked calls – No more than one percent (1%) of calls are blocked;

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- A.9.7.2 Answer rate -- At least ninety percent (90%) of all calls are answered by a live voice within thirty (30) seconds;
- A.9.7.3 Abandoned calls -- No more than five percent (5%) of calls are abandoned; and
- A.9.7.4 Hold time -- Average hold time, including transfers to other CONTRACTOR staff, is no more than three (3) minutes.
- A.9.8 If a NEMT call cannot be answered by a live voice within thirty (30) seconds, the CONTRACTOR shall provide a message in, at a minimum, English and Spanish advising the caller that the call will not be answered promptly and offering the caller the opportunity to leave a message. If the message requests the CONTRACTOR to return the call, the CONTRACTOR shall promptly return the call.
- A.9.9 The CONTRACTOR shall have qualified bi-lingual (English and, at minimum, Spanish) NEMT Call Center staff to communicate with callers who, at a minimum, speak Spanish. The CONTRACTOR shall provide oral interpretation services via a telephone interpretation service free of charge to callers with Limited English Proficiency.
- A.9.10 The CONTRACTOR's NEMT Call Center shall accommodate callers who are hearing and/or speech impaired.
- A.9.11 The CONTRACTOR shall operate an automatic call distribution system for its NEMT Call Center.
- A.9.12 The CONTRACTOR shall route incoming calls to the NEMT Call Center to, at minimum, an English-speaking member queue, a Spanish-speaking member queue, a NEMT provider queue, and a provider queue.
- A.9.13 The welcome message for the NEMT Call Center shall be in English and shall include, at minimum, a Spanish language prompt.
- A.9.14 The CONTRACTOR shall develop NEMT Call Center scripts for calls requesting NEMT services that include a sequence of questions and criteria that the NEMT Call Center representatives shall use to determine the member's eligibility for NEMT services, the appropriate mode of transportation, the purpose of the trip and all other pertinent information relating to the trip (see Section A.4 of this Attachment). The CONTRACTOR may develop additional scripts for other types of NEMT calls from members, providers, and NEMT providers. Any script for use with an enrollee shall be written at the sixth (6th) grade reading level and must be prior approved in writing by TENNCARE.
- A.9.15 The CONTRACTOR shall advise callers that calls to the NEMT Call Center are monitored and recorded for quality assurance purposes.
- A.9.16 The CONTRACTOR shall record a statistically valid sample of incoming and outgoing calls to/from the NEMT Call Center for quality control, program integrity and training purposes.
- A.9.17 The CONTRACTOR shall monitor and audit at least one percent (1%) of calls of each NEMT Call Center staff member on a monthly basis. The CONTRACTOR shall develop a tool for auditing calls, which shall include components to be audited and the scoring methodology. The CONTRACTOR shall use this monitoring to identify problems or issues, for quality control, and for training purposes. The CONTRACTOR shall document and retain results of this monitoring and subsequent training.
- A.9.18 The CONTRACTOR's NEMT Call Center system shall be able to produce the reports specified in Section A.19 of this Attachment as well as on request and ad hoc reports that TENNCARE may request.
- A.9.19 The CONTRACTOR shall analyze data collected from its NEMT Call Center system as necessary to perform quality improvement, fulfill the reporting and monitoring requirements of the Agreement, and ensure adequate resources and staffing.

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A.9.20 Failure to comply with requirements regarding the NEMT Call Center may result in liquidated damages as provided in Section 6-8.2 of the Agreement, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

A.10 NEMT MEMBER EDUCATION

A.10.1 The CONTRACTOR shall develop materials to inform and educate members about NEMT services.

A.10.2 The materials shall include, but not be limited to, information regarding eligibility for NEMT services, what services are covered/not covered, and how to request NEMT services, including the number to call, applicable timeframes, the approval and scheduling process, the use of fixed route, and Standing Orders.

A.10.3 All written materials shall comply with Section 2-6 of the Agreement and must be prior approved in writing by TENNCARE.

A.10.4 Prior to the date of implementation, as specified by TENNCARE, the CONTRACTOR shall mail member education materials to its members by first class mail and at the CONTRACTOR's expense.

A.11 NON-COMPLIANT MEMBERS

A.11.1 The CONTRACTOR shall provide targeted education to members who do not comply with the CONTRACTOR's policies and procedures regarding NEMT services. All member materials shall comply with Section 2-6 of the Agreement and must be prior approved in writing by TENNCARE.

A.11.2 The CONTRACTOR shall not take any action to sanction members who do not comply with the CONTRACTOR's policies and procedures.

A.11.3 Members shall not be charged for no-shows (as defined in Exhibit A of this Attachment).

A.12 NEMT PROVIDER NETWORK

A.12.1 The CONTRACTOR shall establish a network of qualified NEMT providers to provide covered NEMT services to meet the transportation needs of members. In developing its network of qualified NEMT providers the CONTRACTOR shall comply with Section 2-4.1 of the Agreement.

A.12.2 The CONTRACTOR shall have sufficient NEMT providers in its network (numbers and types of vehicles and drivers) so that the failure of any NEMT provider to perform will not impede the ability of the CONTRACTOR to provide NEMT services in accordance with the requirements of the Agreement.

A.12.3 The CONTRACTOR shall ensure that its NEMT providers have a sufficient number of vehicles and drivers available to meet the timeliness requirements of the Agreement (see Section A.5 of this Attachment).

A.12.4 The CONTRACTOR shall provide Human Resource Agencies (HRAs) the opportunity to become a NEMT provider if the HRA is qualified to provide the service and agrees to the terms of the CONTRACTOR's NEMT provider agreement, which shall be no more restrictive than for other NEMT providers and include alternative indemnification language as specified in Section A.13.4 of this Attachment.

A.12.5 The CONTRACTOR shall provide Division of Mental Retardation Services (DMRS) waiver providers (defined as providers who have signed a provider agreement with DMRS and the Bureau of TennCare to provide residential treatment services or day services through a HCBS waiver for individuals with mental retardation) the opportunity to become a NEMT provider if the provider is qualified to provide the service and agrees to the terms of the CONTRACTOR's NEMT provider agreement, which shall be no more restrictive than for other NEMT providers. These providers shall only provide covered NEMT services to members receiving HCBS waiver services from the provider. The State reimburses these providers for transportation services to/from HCBS waiver services. However, the State does not reimburse these providers for transportation to/from other TennCare covered services. The

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CONTRACTOR shall reimburse these providers for covered NEMT services that are not being provided to the member through a HCBS waiver. The CONTRACTOR shall reimburse these providers in accordance with rates paid to other NEMT providers for the provision of NEMT services.

A.12.6 The CONTRACTOR shall ensure that its NEMT providers are qualified to perform their duties. This includes, but is not limited to, meeting applicable federal, state or local licensure, certification, or registration requirements. Failure to comply with requirements regarding licensure requirements may result in liquidated damages as provided in Section 6-8.2 of the Agreement.

A.12.7 The CONTRACTOR's NEMT provider network must be prior approved in writing by TENNCARE and shall be subject to ongoing review and approval by TENNCARE. Failure to comply with NEMT provider network requirements may result in liquidated damages as provided in Section 6-8.2 of the Agreement.

A.13 NEMT PROVIDER AGREEMENTS

A.13.1 All NEMT provider agreements shall comply with applicable requirements of the Agreement, including but not limited to prior written approval of template agreements and revisions thereto by the Tennessee Department of Commerce and Insurance (TDCI).

A.13.2 Except for fixed route, NEMT providers used for contingency or back-up (see Section A.5.9 of this Attachment), or as otherwise agreed to by TENNCARE in writing, the CONTRACTOR shall not use transportation providers with which the CONTRACTOR has not executed a provider agreement.

A.13.3 In addition to the requirements in other sections of the Agreement, all NEMT provider agreements shall meet the following minimum requirements:

A.13.3.1 Include provisions related to payment for cancellations (see Section A.5.5.5 of this Attachment), no-shows (as defined in Exhibit A to this Attachment), escorts, and adults accompanying members under age eighteen (18);

A.13.3.2 Specify the services to be provided by the NEMT provider, including, as applicable, mode(s) of transportation and dispatching.

A.13.3.3 Include expectations for door-to-door, hand-to-hand, and curb-to-curb service (see Section A.4.4 of this Attachment and definitions in Exhibit A of this Attachment);

A.13.3.4 Include or reference trip manifest requirements (see Section A.5.5 of this Attachment);

A.13.3.5 Include urgent trip requirements (see Section A.5.7 of this Attachment);

A.13.3.6 Include or reference back-up service requirements (see Section A.5.9 of this Attachment);

A.13.3.7 Include or reference pick-up and delivery standards (see Section A.6 of this Attachment);

A.13.3.8 Require the NEMT provider to notify the CONTRACTOR of specified events, including no-shows (see Section A.6.2 of this Attachment), accidents, moving traffic violations, and incidents (see Section A.6.9 of this Attachment);

A.13.3.9 Include or reference vehicle standards (see Section A.7 of this Attachment);

A.13.3.10 Require the NEMT provider to notify the CONTRACTOR if a vehicle is out of service or otherwise unavailable;

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- A.13.3.11 Include or reference training requirements for the NEMT provider (see Section A.16.2 of this Attachment) and for drivers (see Section A.8.2 of this Attachment);
- A.13.3.12 Include or reference driver standards (see Section A.8.3), including driver log requirements (see Section A.8.3.16 of this Attachment) and require the NEMT provider to provide copies of driver logs to the CONTRACTOR upon request; and
- A.13.3.13 Require the NEMT provider to secure and maintain adequate insurance coverage prior to providing any NEMT services under the Agreement, including, at minimum, the following:
 - A.13.3.13.1 Workers' Compensation/ Employers' Liability (including all states coverage) with a limit not less than the relevant statutory amount or one million dollars (\$1,000,000) per occurrence for employers' liability whichever is greater;
 - A.13.3.13.2 Comprehensive Commercial General Liability (including personal injury and property damage, premises/operations, independent contractor, contractual liability and completed operations/products) with a bodily injury/property damage combined single limit not less than one million dollars (\$1,000,000) per occurrence and two million dollars (\$2,000,000) in the aggregate; and
 - A.13.3.13.3 Automobile Coverage (including owned, leased, hired, and non-owned vehicles) with a bodily injury/property damage combined single limit not less than one million dollars (\$1,000,000) per occurrence.
- A.13.4 If the CONTRACTOR has a provider agreement with a HRA, the agreement shall meet the requirements specified in Sections A.13.1 and A.13.3 above and shall also include indemnification language negotiated with the HRA and prior approved in writing by TENNCARE as an alternative to the indemnification language referenced in the Agreement.
- A.13.5 Failure to comply with provider agreement requirements may result in liquidated damages as provided in Section 6-8.2 of the Agreement.

A.14 PAYMENT FOR NEMT SERVICES

A.14.1 General

In addition to requirements in the Agreement regarding payment for services, when paying for NEMT services the CONTRACTOR shall comply with the requirements in this Attachment.

A.14.2 Payment for Fixed Route

- A.14.2.1 The CONTRACTOR shall make every effort to provide tickets/tokens/passes to a member in a manner that ensures receipt prior to the scheduled transportation.
- A.14.2.2 If the CONTRACTOR cannot provide tickets/token/passes prior to the scheduled transportation, the CONTRACTOR shall offer the member the choice of having the CONTRACTOR arrange alternate transportation or reimbursing the member for the cost of the applicable fare for the fixed route transportation approved by the CONTRACTOR.
- A.14.2.3 The CONTRACTOR may negotiate agreements with fixed route transportation entities. Such agreements must be prior approved in writing by TENNCARE.

A.14.3 Validation Checks

- A.14.3.1 The CONTRACTOR shall have policies and procedures for conducting random post-transportation validation checks. These policies and procedures must be prior approved in writing by TENNCARE. These policies and procedures shall specify how the CONTRACTOR will conduct post-transportation validation checks (e.g., by calling providers or matching NEMT claims and physical health/behavioral health claims), the frequency of the checks (e.g., one point five percent (1.5%) of NEMT claims received in a month), and any follow-up activities (e.g., if the CONTRACTOR determines that transportation for a particular member was not to a TennCare covered service, the CONTRACTOR validates the next three (3) requests for that member before a trip is approved (see Section A.4.6 of this Attachment)). If the CONTRACTOR suspects fraud or abuse, it shall comply with the fraud and abuse requirements of the Agreement.
- A.14.3.2 The CONTRACTOR shall perform post-transportation validation checks for fixed route transportation as specified in the CONTRACTOR's policies and procedures, which must be prior approved in writing by TENNCARE.

A.15 NEMT CLAIMS MANAGEMENT

- A.15.1 The CONTRACTOR shall process NEMT provider claims consistent with the claims processing requirements of the Agreement.
- A.15.2 The CONTRACTOR shall submit encounter data for NEMT services that meets the requirements in the Agreement, including compliance with HIPAA's electronic transactions and code set requirements.
- A.15.3 The CONTRACTOR shall ensure that ninety percent (90%) of clean claims for payment for NEMT services delivered to a member are processed within thirty (30) calendar days of the receipt of such claims.
- A.15.4 The CONTRACTOR shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all NEMT provider claims for covered NEMT services delivered to a member.
- A.15.5 The CONTRACTOR shall pay ninety-seven percent (97%) of NEMT claims accurately upon initial submission.
- A.15.6 The CONTRACTOR shall conduct an audit of NEMT claims that complies with the requirements in the Agreement regarding a claims payment accuracy audit.
- A.15.7 Failure to comply with requirements regarding NEMT claims management may result in liquidated damages as provided in Section 6-8.2 of the Agreement, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

A.16 NEMT PROVIDER MANUAL AND NEMT PROVIDER EDUCATION AND TRAINING

A.16.1 NEMT Provider Manual

- A.16.1.1 The CONTRACTOR shall issue a NEMT provider manual to all NEMT providers. The CONTRACTOR may distribute the NEMT provider manual electronically (e.g., through its website) so long as NEMT providers are notified about how to obtain the electronic copy and how to request a hard copy at no charge to the NEMT provider.
- A.16.1.2 The NEMT provider manual must be prior approved in writing by TENNCARE and shall include, at a minimum, the following:
 - A.16.1.2.1 Description of the TennCare program;
 - A.16.1.2.2 Covered and non-covered NEMT services, including requirement that transportation must be to a TennCare covered service;

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- A.16.1.2.3 Prior approval requirements;
- A.16.1.2.4 Vehicle requirements;
- A.16.1.2.5 Driver requirements;
- A.16.1.2.6 Protocol for encounter data elements reporting/records;
- A.16.1.2.7 Claims submission protocols and standards, including instructions and all information necessary for a clean claim;
- A.16.1.2.8 Payment policies;
- A.16.1.2.9 Information on members' appeal rights;
- A.16.1.2.10 Member rights and responsibilities;
- A.16.1.2.11 Policies and procedures of the provider complaint system; and
- A.16.1.2.12 Important phone numbers of all departments/staff a NEMT provider may need to reach at the CONTRACTOR's MCO.
- A.16.1.3 The CONTRACTOR shall disseminate bulletins to NEMT providers as needed to incorporate any needed changes to the provider manual.

A.16.2 NEMT Provider Education and Training

- A.16.2.1 The CONTRACTOR shall develop and implement a plan to educate NEMT providers, including initial orientation sessions and continuing education. The initial orientation shall include at minimum the topics included in the NEMT provider manual.
- A.16.2.2 The CONTRACTOR shall ensure that all NEMT provider staff, including but not limited to dispatchers, supervisors, and mechanics, receive appropriate training before providing services under the Agreement and on an ongoing basis thereafter.

A.17 NEMT QUALITY ASSURANCE AND MONITORING

A.17.1 NEMT Quality Assurance Program

- A.17.1.1 As part of the CONTRACTOR's Quality Improvement (QI) Program, the CONTRACTOR shall develop and implement a quality assurance program for NEMT services. The description of the program (the NEMT Quality Assurance Plan) shall include policies and procedures outlining the objectives and scope of the program as well as activities for ongoing monitoring, evaluation and improvement of the quality and appropriateness of NEMT services.
- A.17.1.2 The NEMT Quality Assurance Plan shall include at least the following:
 - A.17.1.2.1 The CONTRACTOR's procedures for monitoring and improving member satisfaction with NEMT services;
 - A.17.1.2.2 The CONTRACTOR's procedures for ensuring that all NEMT services paid for are properly approved and actually rendered, including but not limited to validation checks (see Sections A.4.6 and A.14.3) and an annual analysis matching physical health and behavioral health claims/encounters and NEMT claims/encounters;
 - A.17.1.2.3 The CONTRACTOR's procedures for monitoring and improving the quality of transportation provided pursuant to the Agreement, including transportation provided by fixed route; and
 - A.17.1.2.4 The CONTRACTOR's monitoring plan for NEMT providers, as detailed in Section A.17.3 of this Attachment.

A.17.2 Accidents and Incidents

The CONTRACTOR shall document accidents and incidents that occur while services are being delivered under the Agreement. An incident is defined as an occurrence, event, breakdown, or public disturbance that interrupts the trip, causing the driver to stop the vehicle, such as a passenger being unruly or ill.

A.17.3 NEMT Provider Monitoring Plan

A.17.3.1 The CONTRACTOR shall develop and implement a plan for monitoring NEMT providers' compliance with all applicable local, state and federal law. The plan shall also monitor NEMT providers' compliance with the terms of their provider agreements and all NEMT provider-related requirements of the Agreement, including but not limited to driver requirements, vehicle requirements, member complaint resolution requirements, and the delivery of courteous, safe, timely and efficient transportation services.

A.17.3.2 Monitoring activities shall include, but are not limited to:

A.17.3.2.1 On-street observations;

A.17.3.2.2 Random audits of NEMT providers;

A.17.3.2.3 Accident and incident reporting;

A.17.3.2.4 Statistical reporting of trips;

A.17.3.2.5 Analysis of complaints;

A.17.3.2.6 Driver licensure, driving record, experience and training;

A.17.3.2.7 Enrollee safety;

A.17.3.2.8 Enrollee assistance;

A.17.3.2.9 Completion of driver trip logs;

A.17.3.2.10 Driver communication with dispatcher; and

A.17.3.2.11 Routine scheduled vehicle inspections and maintenance.

A.17.4 NEMT Provider Corrective Action

A.17.4.1 The CONTRACTOR shall have policies and procedures for ensuring that an appropriate corrective action is taken when a NEMT provider furnishes inappropriate or substandard services, when a NEMT provider does not furnish services that should have been furnished, or when a NEMT provider is out of compliance with federal, state, or local law.

A.17.4.2 The CONTRACTOR shall immediately remove from service any vehicle, driver, or EMT found to be out of compliance with the requirements of the Agreement, including any federal, state or local law. The vehicle, driver, or EMT may be returned to service only after the CONTRACTOR verifies that the deficiencies have been corrected. Any deficiencies, and actions taken to remedy deficiencies, shall be documented and become a part of the vehicle's and/or the person's permanent records.

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- A.17.4.3 As required in Section A.19.6.7 of this Attachment, the CONTRACTOR shall report on monitoring activities, monitoring findings, corrective actions taken, and improvements made.

A.17.5 NEMT Member Satisfaction Survey

- A.17.5.1 The CONTRACTOR shall conduct a member satisfaction survey regarding NEMT services for the first six (6) months after implementation of the requirements in this Attachment or as otherwise specified by TENNCARE and annually thereafter.
- A.17.5.2 The purpose of the survey is to verify the availability, appropriateness and timeliness of the trips provided and the manner in which the CONTRACTOR's staff and the NEMT provider's staff interacted with members.
- A.17.5.3 The survey topics shall include, but are not limited to:
- A.17.5.3.1 NEMT Call Center interaction;
 - A.17.5.3.2 Confirmation of a scheduled trip;
 - A.17.5.3.3 Driver and CONTRACTOR staff courtesy;
 - A.17.5.3.4 Driver assistance, when required;
 - A.17.5.3.5 Overall driver behavior;
 - A.17.5.3.6 Driver safety and operation of the vehicle;
 - A.17.5.3.7 Condition, comfort and convenience of the vehicle; and
 - A.17.5.3.8 Punctuality of service.
- A.17.5.4 The format, sampling strategies and questions of the survey must be prior approved in writing by TENNCARE, and TENNCARE may specify questions that are to appear in the survey.
- A.17.5.5 The CONTRACTOR shall submit reports regarding these surveys as required in Section A.19.6.8 of this Attachment.

A.17.6 Vehicle Inspection

- A.17.6.1 The CONTRACTOR shall conduct a comprehensive inspection of all NEMT providers' vehicles prior to the implementation of NEMT requirements in this Attachment. Thereafter, the CONTRACTOR shall conduct a comprehensive inspection of all vehicles at least annually. The CONTRACTOR is not required to inspect fixed route vehicles, invalid vehicles, ambulances, or vehicles for NEMT providers with which the CONTRACTOR does not have a provider agreement (see Section A.13.2 of this Attachment).
- A.17.6.2 The CONTRACTOR shall develop and implement policies and procedures for vehicle inspections. These policies and procedures must be prior approved in writing by TENNCARE and shall include inspection forms, inspection stickers and a list of trained inspectors, including the names of all employees or subcontractors who are authorized to inspect vehicles for the CONTRACTOR. Inspection forms shall have a checklist that includes all the applicable vehicle standards of the Agreement and of local, state and federal law. The CONTRACTOR shall test all communication equipment during all vehicle inspections.

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- A.17.6.3 Upon completion of a successful inspection, an inspection sticker shall be applied to the vehicle. The inspection sticker shall be placed on the outside of the passenger side rear window in the lower right corner. The sticker shall state the license plate number and vehicle identification number of the vehicle. Records of all inspections shall be maintained by the CONTRACTOR.

A.18 NEMT SUBCONTRACTS

If the CONTRACTOR delegates any of its responsibilities regarding NEMT services, it shall comply with the subcontracting requirements in the Agreement, including prior written approval of the subcontract by TENNCARE.

A.19 NEMT REPORTING

A.19.1 NEMT Status Reports

- A.19.1.1 During the initial six (6) months after implementation of NEMT services pursuant to this Attachment, and longer if requested by TENNCARE, the CONTRACTOR shall submit a weekly status report. This report shall include, but not be limited to, a NEMT narrative summary of accomplishments, identification of open and closed issues, key Call Center telephone statistics (e.g., number of calls received, number/percentage of calls placed on hold, average hold time, number/percentage of abandoned calls; average talk time; and number of staff to answer calls by time of day/day of week), key statistics on requests for transportation (e.g., number of requests by mode of transportation, number denied and approved, and mode of transportation approved); and key statistics on pick-up and delivery standards.

- A.19.1.2 The CONTRACTOR shall submit a monthly status report. This report shall include, but not be limited to, summary and detail information on accomplishments, outstanding issues, NEMT Call Center statistics, NEMT Call Center activities, and statistics regarding pick-up and delivery standards.

A.19.2 Approval and Utilization Reports

- A.19.2.1 Approval Report. The CONTRACTOR shall submit a quarterly approval report that includes both summary and detail information on transportation requested, approved, modified and denied, including the modification and denial reason. The report shall provide this information by mode of transportation and category of service.

- A.19.2.2 Approval and Scheduling Timeframes Report. The CONTRACTOR shall submit a quarterly report that provides information on timeframes for approving/denying and scheduling transportation.

- A.19.2.3 Pick-up and Delivery Standards Report. The CONTRACTOR shall submit a monthly report that documents the number and percentage of pick-ups that were missed by a NEMT provider, pick-ups or drop-offs that were late, and drop-offs where the member missed an appointment and provides the average amount of time that the pick-ups or drop-offs were late. This information shall be provided by mode of transportation and by county.

- A.19.2.4 Utilization Report. The CONTRACTOR shall submit a monthly utilization that provides both summary and detail information on NEMT services provided to members. The report shall include, at minimum, by mode of transportation and category of service: the number of trips, number of unduplicated members, and number of miles.

A.19.3 NEMT Call Center Reports

- A.19.3.1 The CONTRACTOR shall submit a monthly report that provides summary and detail statistics on the NEMT Call Center telephone lines/queues and includes identification of potential issues, trends, and any corrective action taken.

Amendment 18 (cont.)

- A.19.3.2 The CONTRACTOR shall submit a monthly report that summarizes the results of the CONTRACTOR's call monitoring and any corrective action taken.

A.19.4 NEMT Provider Enrollment File

The CONTRACTOR's monthly provider enrollment file shall include NEMT providers. In addition, the CONTRACTOR shall provide the following information to TENNCARE:

- A.19.4.1 Driver Roster. The CONTRACTOR shall provide a driver roster for each NEMT provider that includes, at minimum: the driver's name, license number, and social security number.
- A.19.4.2 Vehicle Listing. The Contractor shall provide a vehicle listing for each NEMT provider that includes, at minimum: the type of vehicle and the vehicle's manufacturer, model, model year, and vehicle identification number.

A.19.5 NEMT Claims Management Reports

- A.19.5.1 The CONTRACTOR shall submit a quarterly NEMT prompt payment report. The report shall include the number and percentage of clean NEMT claims that are processed within thirty (30) calendar days of receipt, the number and percentage of NEMT claims that are processed within sixty (60) calendar days of receipt, the number and percentage of NEMT claims and the dollar value and percentage of dollars associated with claims that are processed within the timeframes specified by TENNCARE (e.g., fifteen (15) days, thirty (30) days, etc.), and the average time (number of days) that it takes to process NEMT claims.
- A.19.5.2 The CONTRACTOR shall submit a quarterly NEMT claims payment accuracy report. The report shall be based on an audit conducted by the CONTRACTOR in accordance with Section 2-9.12.2 of the Agreement using a random sample of all "processed or paid" NEMT claims. The report shall include the number and percentage of NEMT claims that are paid accurately for each month in the quarter.

A.19.6 NEMT Quality Assurance and Monitoring Reports

- A.19.6.1 Member NEMT Complaint Report. The CONTRACTOR shall submit a quarterly member complaints report (see Section 1-3 of the Agreement for the definition of complaint, which includes both written and verbal statements) that summarizes the number of complaints regarding NEMT by type, analyzes the information, particularly noting patterns or trends, and describes any corrective action taken to ensure quality of services.
- A.19.6.2 NEMT Provider Complaint Report. The CONTRACTOR shall submit a quarterly NEMT provider complaints report that summarizes the number of verbal and written complaints by type, analyzes the information, including patterns or trends, and describes any corrective action.
- A.19.6.3 NEMT Quality Assurance Plan. As part of its annual Quality Improvement (QI) reporting, the CONTRACTOR shall submit an annual NEMT quality assurance plan (see Section A.17.1 of this Attachment).
- A.19.6.4 NEMT Validation Checks.
- A.19.6.4.1 The CONTRACTOR shall submit a quarterly report summarizing the pre-transportation validation checks (see Section A.4.6 of this Attachment) conducted by the CONTRACTOR, the findings, and any corrective actions.
- A.19.6.4.2 The CONTRACTOR shall submit a quarterly report summarizing the post-transportation validation checks (see Section A.14.3 of this Attachment) conducted by the CONTRACTOR, the findings, and any corrective actions.

Amendment 18 (cont.)

- A.19.6.5 Post-Payment Review Report. The CONTRACTOR shall submit an annual report summarizing the methods and findings for the post-payment review (see Section A.17.1.2.2 of this Attachment) and identifying opportunities for improvement.
- A.19.6.6 Accidents and Incidents.
- A.19.6.6.1 Immediately upon becoming aware of any accident resulting in driver or passenger injury or fatality that occurs while providing services under the Agreement, the CONTRACTOR shall notify TENNCARE. The CONTRACTOR shall submit a written accident report within five (5) business days of the accident and shall cooperate in any related investigation. A police report shall be included in the accident report or provided as soon as possible.
- A.19.6.6.2 The CONTRACTOR shall submit a quarterly report of all accidents, moving traffic violations, and incidents.
- A.19.6.7 Monitoring Plan.
- A.19.6.7.1 The CONTRACTOR shall submit an annual NEMT provider monitoring plan (see Section A.17.3 of this Attachment).
- A.19.6.7.2 The CONTRACTOR shall submit an annual report summarizing its monitoring activities, the findings, corrective actions, and improvements for NEMT services provided under the Agreement.
- A.19.6.8 Satisfaction Survey Report. The CONTRACTOR shall submit a report (three months after the initial survey period and then annually) summarizing the member survey methods and findings and identifying opportunities for improvement.

A.20 Performance Standards

The CONTRACTOR agrees that TENNCARE may assess liquidated damages against the CONTRACTOR for failure to meet the performance standards as specified in Exhibit F of this Attachment.

All of the provisions of the original Contract not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective May 1, 2008.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

BY: M D Goetz Jr / sca
M. D. Goetz, Jr.
Commissioner

DATE: 5/21/08

VOLUNTEER STATE HEALTH PLAN, INC.

BY: Sonya Nelson
Sonya Nelson
President and Chief Executive Officer

DATE: 5/4/08

APPROVED BY:

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

BY: M. D. Goetz, Jr.
M. D. Goetz, Jr.
Commissioner

DATE: 5/22/08

APPROVED BY:

**STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY**

BY: John G. Morgan
John G. Morgan
Comptroller

DATE: 5/28/08

Exhibit A
DEFINITIONS, ACRONYMS, AND ABBREVIATIONS

The terms used in this Attachment shall be given the meaning used in TennCare rules and regulations. However, the following terms, when used in this Attachment, shall be construed and/or interpreted as follows, unless the context expressly requires a different construction and/or interpretation.

Definitions

1. **Commercial Carrier Transport:** Transportation provided by a common carrier, including but not limited to buses (e.g., Greyhound), trains (e.g., Amtrak), airplanes, and ferries.
2. **Curb-to-Curb Service:** Transportation provided to passengers who need little if any assistance between the vehicle and the door of the pick-up point or destination. The driver shall provide assistance according to the enrollee's needs, including assistance as necessary to enter and exit the vehicle, but assistance shall not include the lifting of any enrollee. The driver shall remain at or near the vehicle and not enter any buildings.
3. **Door-to-Door Service:** Transportation provided to enrollees with disabilities who need assistance to safely move between the door of the vehicle and the door of the passenger's pick-up point or destination. The driver shall exit the vehicle and assist the enrollee from the door of the pick-up point, e.g., residence, accompany the passenger to the door of the vehicle, and assist the passenger in entering the vehicle. The driver shall assist the enrollee throughout the transport and to the door of the destination.
4. **Federal Motor Carrier Safety Administration (FMCSA):** A separate administration within the United States Department of Transportation established pursuant to the Motor Carrier Safety Improvement Act of 1999. Its primary mission is to reduce crashes, injuries, and fatalities involving large trucks and buses.
5. **Fixed Route:** Transportation by means of a public transit vehicle that follows an advertised route on an advertised schedule, does not deviate from the route or the schedule, and picks up passengers at designated stops. Fixed route transportation includes, but is not limited to, non-commercial buses, commuter trains, and trolleys.
6. **Hand-to-Hand Service:** Transportation of an enrollee with disabilities from an individual at the pick-up point to a provider staff member, family member or other responsible party at the destination.
7. **Hospital Discharge:** Notification by a hospital that an enrollee is ready for discharge. A hospital discharge shall be considered an urgent trip.
8. **HRAs:** Human Resource Agencies. These agencies are the delivery system for human services, including transportation to rural residents, throughout the State of Tennessee. The nine HRAs are: Delta HRA, East Tennessee HRA, First Tennessee HRA, Mid-Cumberland HRA, Northwest HRA, South Central Development District, South West HRA, Upper Cumberland HRA, and South East HRA.
9. **No- Show:** A trip is considered a no-show when the driver arrived on time, made his/her presence known, and the member is not present five (5) minutes after the scheduled pick-up time.
10. **Private Automobile:** An enrollee's personal vehicle or the personal vehicle of a family member or friend, to which the enrollee has access. Private automobile is not a covered NEMT service.
11. **Single Trip:** Transport to and/or from a single TennCare covered service. A trip generally has at least two (2) trip legs but there can be one (1) or more than two (2) (multiple) trip legs.

Amendment 18 (cont.)

12. **Standing Order:** Transport to and/or from multiple recurring medical appointments for TennCare covered services for the same enrollee with the same provider for the same treatment or condition (can be one (1) or multiple trip legs).
13. **TennCare Covered Services:** The health care services available to TennCare enrollees, as defined in TennCare rules and regulations. This includes, but is not limited to, physical health, behavioral health, pharmacy, and dental services provided through managed care contractors (MCCs), as well as institutional services and alternatives to institutional services (home and community based waiver services) provided by entities that are not MCCs. TennCare covered services includes TENNderCare services.
14. **Tennessee Division of Mental Retardation Services (DMRS):** The state agency responsible for providing services and supports to Tennesseans with mental retardation. DMRS is a division of the Tennessee Department of Finance and Administration.
15. **Trip Leg:** One-way transport from a pick-up point to a destination. A trip generally has at least two (2) trip legs.
16. **Urgent Trip:** Covered NEMT services required for an unscheduled episodic situation in which there is no immediate threat to life or limb but the enrollee must be seen on the day of the request (can be one (1) or multiple trip legs). A hospital discharge shall be an urgent trip.

Exhibit B
TRIP MANIFESTS

The trip manifests supplied to NEMT providers shall include all necessary information for the driver to perform the trip for each enrollee, including but not limited to:

1. Number assigned by the CONTRACTOR for approved trip;
2. NEMT provider name;
3. The mode of transportation;
4. MCO/BHO name;
5. Enrollee's name;
6. Enrollee's age;
7. Enrollee's sex;
8. Trip date;
9. Number of legs for the trip (e.g., one-way, round trip, or multiple legs);
10. Origin of trip/place of pick-up (e.g., residence)
11. Time of pick-up for the time zone applicable to the pick-up location;
12. Address of the pick-up, including street address, city, county, state, and zip code;
13. Enrollee's phone number(s);
14. Number of riders;
15. Time of appointment for the time zone applicable to the appointment location;
16. Provider name;
17. Address of the provider, including street address, city, county, state, and zip code;
18. Provider's phone number(s);
19. Return trip times for the applicable time zone(s) and addresses, if applicable;
20. Any additional stops (e.g., pharmacy);
21. Any special needs of the enrollee;
22. Any special instructions to the driver, e.g., door-to-door or hand-to-hand service;
23. Whether enrollee has third party coverage, including Medicare; and
24. Notes.

The CONTRACTOR may express time in regular time (AM or PM) or in military time (using the 24-hour clock); however, the selected method for expressing time (regular or military) shall be used consistently by the CONTRACTOR and by all of the CONTRACTOR's subcontractors, NEMT providers and drivers.

Exhibit C
VEHICLE REQUIREMENTS

All vehicles, except for fixed route vehicles and ambulances, shall meet the following requirements:

1. The number of persons in the vehicle, including the driver, shall not exceed the vehicle manufacturer's approved seating capacity.
2. All vehicles shall have adequately functioning heating and air-conditioning systems.
3. All vehicles shall have functioning, clean and accessible seat belts for each passenger seat position. All vehicles shall have an easily visible interior sign that states: "ALL PASSENGERS SHALL USE SEAT BELTS". Seat belts shall be stored off the floor when not in use.
4. Each vehicle shall use child safety seats in accordance with state law.
5. All vehicles shall have at least two (2) seat belt extensions.
6. For use in emergency situations, each vehicle shall be equipped with at least one (1) seat belt cutter that is kept within easy reach of the driver.
7. All vehicles shall have functioning interior light(s) within the passenger compartment.
8. All vehicles shall have an accurate, operating speedometer and odometer.
9. All vehicles shall have two (2) exterior rear view mirrors, one (1) on each side of the vehicle.
10. All vehicles shall be equipped with an interior mirror for monitoring the passenger compartment.
11. The exterior of all vehicles shall be clean and free of broken mirrors or windows, excessive grime, major dents, or paint damage that detract from the overall appearance of the vehicles.
12. The interior of all vehicles shall be clean and free of torn upholstery, floor or ceiling covering; damaged or broken seats; protruding sharp edges; dirt, oil, grease or litter; or hazardous debris or unsecured items.
13. All vehicles shall be smooth riding, so as not to create passenger discomfort.
14. All vehicles shall have the NEMT provider's business name and telephone number decaled on at least both sides of the exterior of the vehicle. The business name and phone number shall appear in lettering that is a minimum of three inches in height and of a color that contrasts with its surrounding background.
15. To comply with confidentiality requirements, no words may be displayed on the vehicle that implies that TennCare enrollees are being transported. The name of the NEMT provider's business may not imply that TennCare enrollees are being transported.
16. The vehicle license number and the CONTRACTOR's toll-free phone number shall be prominently displayed on the interior of each vehicle. This information and the complaint procedures shall be clearly visible and available in written format (at a minimum, in English and Spanish) in each vehicle for distribution to enrollees upon request.
17. The vehicle shall have a current inspection sticker issued by the CONTRACTOR on the outside of the passenger side rear window in the lower right corner.
18. Smoking shall be prohibited in all vehicles at all times. All vehicles shall have an easily visible interior sign that states: "NO SMOKING".
19. All vehicles shall carry a vehicle information packet containing vehicle registration, insurance card, and accident procedures and forms.
20. All vehicles shall be equipped with a first aid kit stocked with antiseptic cleansing wipes, triple antibiotic ointment, assorted sizes of adhesive and gauze bandages, tape, scissors, latex or other impermeable gloves, and sterile eyewash.
21. Each vehicle shall contain a current map of the applicable geographic area with sufficient detail to locate enrollee and provider addresses.

Amendment 18 (cont.)

22. Each vehicle shall be equipped with a regulation size Class B chemical type fire extinguisher. The fire extinguisher shall have a visible, current (up-to-date) inspection tag or sticker showing an inspection of the fire extinguisher by the appropriate authority within the past twelve (12) months. The extinguisher shall be mounted in a bracket located in the driver's compartment and be readily accessible to the driver and passenger(s).
23. Each vehicle shall be equipped with a "spill kit" that includes liquid spill absorbent, latex or other impermeable gloves, hazardous waste disposal bags, scrub brush, disinfectant and deodorizer.
24. Each vehicle shall be equipped with emergency triangles.
25. Each vehicle that is required to stop at all railroad crossings shall have a railroad crossing decal that says that the vehicle stops at all railroad crossings.
26. Each vehicle shall have a real-time link, telephone or two-way radio. Pagers are not acceptable as a substitute.

Exhibit D
DRIVER REQUIREMENTS

The requirements listed below shall apply to all drivers of vehicles other than fixed route vehicles and ambulances.

1. All drivers shall be courteous, patient, and helpful to all passengers.
2. All drivers shall be neat and clean in appearance.
3. No driver shall use alcohol, narcotics, illegal drugs or prescription medications that impair the ability to perform while on duty. No driver shall abuse alcohol or prescription medications or use illegal drugs at any time.
4. All drivers shall wear and have visible an identification badge that is easily readable and identifies the driver and the NEMT provider.
5. No driver shall smoke or eat while in the vehicle, while assisting an enrollee, or in the presence of any enrollee.
6. Drivers shall not wear any type of headphones at any time while on duty, with the exception of hands-free headsets for mobile telephones. Mobile telephones may only be used for communication with the NEMT provider, the dispatcher, or the CONTRACTOR.
7. Drivers shall exit the vehicle to open and close vehicle doors when passengers enter or exit the vehicle.
8. The driver shall provide an appropriate level of assistance to an enrollee when requested or when necessitated by the enrollee's mobility status or personal condition. This includes curb-to-curb, door-to-door, and hand-to-hand service, as required.
9. The driver shall assist enrollees in the process of being seated including the fastening of seat belts, securing children in properly-installed child safety seats, and properly securing passengers in wheelchairs.
10. The driver shall confirm, prior to departure, that all seat belts are fastened properly, and that all passengers, including passengers in wheelchairs, are safely and properly secured.
11. Upon arrival at the destination, the driver shall park the vehicle so that the enrollee does not have to cross streets to reach the entrance of the destination.
12. Drivers shall visually confirm that the enrollee is inside the destination.
13. The driver shall not leave an enrollee unattended at any time.
14. If an enrollee or other passenger's behavior or any other condition impedes the safe operation of the vehicle, the driver shall park the vehicle in a safe location out of traffic, notify the NEMT provider/dispatcher, and request assistance.

Exhibit E
DRIVER LOGS

The CONTRACTOR shall require that the NEMT providers' drivers maintain daily transportation logs containing, at a minimum, the information listed below. Fixed route transportation is excluded from this requirement.

1. Date of service;
2. Driver's name;
3. Driver's signature;
4. Name of escort or accompanying adult (for enrollees under age eighteen (18) and relationship to enrollee (if applicable));
5. Vehicle Identification Number (VIN);
6. Enrollee's name;
7. The NEMT provider's name;
8. Number assigned by the CONTRACTOR for the approved trip;
9. Mode of transportation approved;
10. Actual start time (from the base station) for the time zone applicable to the starting location;
11. Scheduled pick-up time for the time zone applicable to the pick-up location;
12. Actual pick-up location and time for the time zone applicable to the pick-up location;
13. Actual departure time from pick-up location for the time zone applicable to the pick-up location;
14. Actual destination and time for the time zone applicable to the destination;
15. Actual number of wheelchairs, escorts, and accompanying adults (for enrollees under age eighteen (18));
16. Odometer readings at each point of pick-up and of drop-off; and
17. Notes, if applicable. At a minimum, the log shall show notes in the case of cancellations, incomplete requests, "no-shows", accident and incident.

For ambulance, the log shall also contain, at a minimum:

1. Patient assessment by ambulance personnel and a chronological narrative of care/service rendered by ambulance personnel;
2. Itemized list of specialized services and/or supplies; and
3. Type of vehicle used for transport (class or service category).

The CONTRACTOR may express time in regular time (AM or PM) or in military time (using the 24-hour clock); however, the selected method for expressing time (regular or military) shall be used consistently by the CONTRACTOR and by all of the CONTRACTOR's subcontractors, NEMT providers and drivers.

Exhibit F
PERFORMANCE STANDARDS AND LIQUIDATED DAMAGES

No.	PERFORMANCE STANDARD	LIQUIDATED DAMAGE
1	Ensure that members receive the appropriate level of service (see Section A.4.4 of this Attachment)	\$500 per deficiency
2	Comply with the approval and scheduling timeframes (see Section A.5.1.3 of this Attachment)	\$1,000 per deficiency
3	Comply with requirements regarding urgent trips (see Section A.5.7 of this Attachment)	\$500 per deficiency
4	Comply with pick-up and delivery standards (see Section A.6 of this Attachment)	\$100 per deficiency
5	Comply with vehicle standards (see Section A.7 of this Attachment)	<p>\$1,500 per calendar day per vehicle that is not in compliance with ADA requirements</p> <p>\$1,000 per vehicle that is allowed into service without an inspection in accordance with the requirements of the Agreement</p> <p>\$2,500 per calendar day per vehicle that is not in compliance with a vehicle standard that would endanger health or safety for vehicle occupants</p> <p>\$500 per calendar day per vehicle that is not in compliance with a vehicle standard that creates passenger discomfort or inconvenience</p> <p>\$100 per calendar day per vehicle that is not in compliance with an administrative vehicle standard</p>
6	Comply with driver training requirements and driver standards (see Section A.8 of this Attachment)	\$2,500 per calendar day per driver for each calendar day that a driver is not in compliance with the driver standards
7	No more than 1% of calls to the NEMT Call Center are blocked (see Section A.9 of this Attachment)	<p>For the first deficiency: \$5,000 for each full percentage point above 1% per month per line/queue</p> <p>For the second deficiency: \$10,000 for each full percentage point above 1% per month per line/queue</p> <p>For the third and subsequent deficiencies: \$15,000 for each full percentage point above 1% per month per line/queue</p>
8	90% of all calls to the NEMT Call Center are answered by a live voice within thirty (30) seconds (see Section A.9 of this Attachment)	<p>For the first deficiency: \$5,000 for each full percentage point below 90% per month per line/queue</p> <p>For the second deficiency: \$10,000 for each full percentage point below 90% per month per line/queue</p> <p>For the third and subsequent deficiencies: \$15,000 for each full percentage point below 90% per month per line/queue</p>

Amendment 18 (cont.)

No.	PERFORMANCE STANDARD	LIQUIDATED DAMAGE
9	Less than 5% of calls to the NEMT Call Center are abandoned (see Section A.9 of this Attachment)	For the first deficiency: \$5,000 for each full percentage point above 5% per month per line/queue For the second deficiency: \$10,000 for each full percentage point above 5% per month per line/queue For the third and subsequent deficiencies: \$15,000 for each full percentage point above 5% per month per line/queue
10	Average hold time for calls to the NEMT Call Center is no more than 3 minutes (see Section A.9 of this Attachment)	For the first deficiency: \$5,000 for each 10 seconds over 3 minutes per month per line/queue For the second deficiency: \$10,000 for each 10 seconds over 3 minutes per month per line/queue For the third and subsequent deficiencies: \$15,000 for each 10 seconds over 3 minutes per month per line/queue
11	Process 90% of clean NEMT claims within thirty (30) calendar days of the receipt of the claim and process 99.5% of claims within sixty (60) calendar of receipt (see Section A.15.3 and Section A.15.4 of this Attachment)	\$10,000 for each month determined not to be in compliance
12	97% of NEMT claims are paid accurately upon initial submission (see Section A.15.5 of this Attachment)	\$5,000 for each full percentage point accuracy is below 97% for each quarter

CONTRACT SUMMARY SHEET

RFS Number:	318.66-026	Contract Number:	FA-02-14632-17
State Agency:	Department of Finance and Administration	Division:	Bureau of TennCare

Contractor	Contract Identification Number
VSHP (TennCare Select)	<input type="checkbox"/> V- <input type="checkbox"/> C-

Service Description

Managed Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medicaid Population

Contract Begin Date	Contract End Date
7/1/2001	6/30/2008

Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66	4A2	134	11	<input type="checkbox"/> STARS		
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)	
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$	18,599,868.48
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$	33,079,942.80
2004	\$ 25,125,990.72	\$ 38,364,165.90			\$	63,490,156.62
2005	\$ 58,007,447.00	\$ 58,007,447.00			\$	116,014,894.00
2006	\$87,748,111.00	\$87,748,111.00			\$	\$175,496,222.00
2007	\$87,748,111.00	\$87,748,111.00			\$	\$175,496,222.00
2008	\$72,610,000.00	\$127,390,000.00			\$	\$200,000,000.00
Total:	\$353,780,720.35	\$ 428,396,585.55			\$	\$782,177,305.90

OCR RELEASED
 JUN 29 2007
 Agency
 TO ACCOUNTS

CFDA#	93.778 Title XIX Dept. of Health & Human Svcs.	Check the box ONLY if the answer is YES:
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State Fiscal Contract		
Name:	Scott Pierce	Is the Contractor a SUBRECIPIENT? (per OMB A-133)
Address:	310 Great Circle Road	Is the Contractor a Vendor? (per OMB A-133)
Phone:	Nashville, TN (615)507-6415	Is the Fiscal Year Funding STRICTLY LIMITED?
Procuring Agency Budget Officer Approval Signature		Is the Contractor on STARS?
Scott Pierce		Is the Contractor's FORM W-9 ATTACHED?
		Is the Contractor's Form W-9 Filed with Accounts?

COMPLETE FOR ALL AMENDMENTS (only)			Funding Certification
CONTRACT END DATE:	Base Contract & Prior Amendments	This Amendment ONLY	Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.
	12/31/2007	6/30/2008	
FY: 2002	\$ 18,599,868.48		
FY: 2003	\$ 33,079,942.80		
FY: 2004	\$ 63,490,156.62		
FY: 2005	\$116,014,894.00		
FY: 2006	\$175,496,222.00		
FY: 2007	\$175,151,878.00		
FY: 2008		\$200,000,000.00	
Total:	\$582,177,305.90	\$200,000,000.00	

RECEIVED
 2007 JUN 25 AM 10:30
 COMPTROLLER'S OFFICE
 OFFICE OF
 MANAGEMENT SERVICES

OCR
 JUN 22 2007
 RECEIVED

AMENDMENT NUMBER 17

**AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.**

CONTRACT NUMBER: FA-02-14632-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as follows:

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. Section 1-3 shall be amended by adding a definition for "Intervention".

Intervention - An action or ministrations that is intended to produce an effect or that is intended to alter the course of a pathologic process.

2. Section 2-1.m shall be deleted and replaced as follows:

- m. Agree to report all provider related data required pursuant to this Agreement to TENNCARE using uniform provider numbers. The uniform numbers to be reported for all providers except pharmacy will be the National Provider Identifier (NPI) Number issued by CMS, where applicable, and the traditional "Medicaid" provider number issued by TENNCARE. Prior to payment of a claim, the MCO shall require that providers that have not been enrolled in the TennCare Program previously as a Medicaid provider or as a provider who currently receives direct payment from TENNCARE (i.e., Medicare cost sharing) contact the Medicaid/TennCare Provider Enrollment Unit and obtain a "Medicaid" provider number. The issuance of a "Medicaid" provider number by TennCare is simply for the purpose of establishing a common provider number for reporting purposes as required by this Section and does not imply that TENNCARE has credentialed the provider or convey any other contractual relationship or any other responsibility with the provider. Pharmacy providers shall use the National Association Board of Pharmacy (NABP) number that has been assigned as well as the NPI number issued by CMS, where applicable. The CONTRACTOR agrees to utilize CMS's newly established NPI numbers for all provider reporting purposes in accordance with timeframes established by CMS, including but not limited to, the development of contingency plans, beginning May 23, 2007 and the implementation of final plans thereafter.

3. Section 2-3.12.3 (c) shall be amended by adding a new sentence to the end of the existing text.

- 2-3.12.3 (c) The individual or her authorized representative, if any, must sign and date a "STATEMENT OF RECEIPT OF INFORMATION CONCERNING HYSTERECTOMY" form, contained in this Agreement as Attachment VII, prior to the hysterectomy. Informed consent must be obtained regardless of diagnosis or age in accordance with Federal requirements. The form shall be available in English and Spanish, and assistance must be provided in completing the form when an alternative form of communication is necessary. See attached form and instructions for additional guidance and exceptions.

Amendment 17 (cont.)

4. Section 2-3.17.7(1) shall be amended by adding a new Section 2-3.17.7(1)d.

d. MCOs must have the ability to conduct EPSDT outreach in formats appropriate to enrollees who are blind, deaf, illiterate or non-English speaking. At least one of the 6 outreach attempts identified above must advise enrollees regarding how to request and/or access such assistance and/or information. The CONTRACTOR shall collaborate with agencies that have established procedures for working with special populations in order to develop effective outreach materials.

5. Section 2-3.17.7 (2) and (3) shall be deleted and replaced as follows:

(2) The CONTRACTOR shall have a written process for following up with members who do not get their screenings timely. The MCO must have a mechanism for maintaining records of efforts made to reach out to children who have missed screening appointments or who have failed to receive regular check-ups. The MCO must make at least one effort each quarter to get such children in for a screening. These efforts are in addition to the efforts described in Section 2-3.17.7(1) above and must be a different written or oral strategy each quarter. It will not be adequate to simply send the same letter four times.

(3) The MCO must have a process for determining if someone eligible for EPSDT has used no services within a year. The MCO must make two reasonable attempts to re-notify such members about EPSDT. One of these attempts can be to refer the member/family to the local health department for a screen. (These two attempts are in addition to the one attempt per quarter mentioned above.)

6. Section 2.3.20 shall be deleted and replaced as follows:

2.3.20 Coordination with the Department of Education

The CONTRACTOR is responsible for the delivery of medically necessary covered services to school-aged children. MCOs are encouraged to work with school-based providers and the Department of Health's Project Teach staff to manage the care of students with special health care needs. The State has implemented a process, referred to as TENNderCARE Connection, to facilitate notification of MCOs when a school-aged child enrolled in TennCare has an Individualized Education Plan (IEP) that identifies a need for medical services. In such cases, the school is responsible for obtaining parental consent to share the IEP with the MCO and for subsequently sending a copy of the parental consent and IEP to the MCO. The school is also responsible for clearly delineating the services on the IEP that the MCOs are to consider for payment. The CONTRACTOR must designate a contact person to whom correspondence concerning children with medical services included in their IEPs will be directed. After receipt of an IEP, the MCO must:

(a) Either accept the IEP as indication of a medical problem and treat the IEP as a request for service authorization and assist, if necessary, in making an appointment to have the child evaluated by the child's PCP or another in-network provider in accordance with the time frames specified in the TennCare Waiver Terms and Conditions for access to care.

(b) Send a copy of the IEP and any related information (e.g. action taken by the MCO in response to receipt of the IEP, action the MCO expects the PCP to take) to the PCP.

(c) Notify the designated school contact of the ultimate disposition of the request (e.g. what services have been approved for the child, what arrangements have been made for service delivery).

7. Section 2-4.1.1 and 2-4.1.2 shall be deleted and replaced as follows:

2-4.1.1. Primary Care Providers (PCPs)

- (a) With the exception of members dually eligible for Medicare and TennCare, the CONTRACTOR shall ensure that each member has an assigned PCP, as defined in Section 1-3, who is responsible for coordinating the covered services provided to the member.
- (b) The CONTRACTOR shall assure that there are PCPs, willing and able to provide the level of care and range of services necessary to meet the medical needs of its members, including those with chronic conditions. There shall be a sufficient number of PCPs who accept new TennCare members within the CONTRACTOR's service area so that the CONTRACTOR meets the Terms and Conditions for Access provided in Attachment III.
- (c) The CONTRACTOR shall offer each member (other than members who are dually eligible for Medicare and TennCare) the opportunity to select a PCP.
- (d) The CONTRACTOR may, at its discretion, allow vulnerable populations (for example, persons with multiple disabilities, acute, or chronic conditions, as determined by the CONTRACTOR) to select their attending specialists as their PCP so long as the specialist is willing to perform responsibilities of a PCP as defined in Section 1-3.
- (e) If a member who is not dually eligible for Medicare and TennCare fails or refuses to select a PCP from those offered within thirty (30) calendar days of enrollment, the CONTRACTOR shall assign a PCP. The CONTRACTOR may assign a PCP in less than thirty (30) calendar days if the CONTRACTOR provides the enrollee an opportunity to change PCPs upon receipt of notice of PCP assignment.
- (f) The CONTRACTOR shall establish policies and procedures to enable members reasonable opportunities to change PCPs. Such policies and procedures may not specify a length of time greater than twelve (12) months between PCP changes under normal circumstances. If the ability to change PCPs is limited, the CONTRACTOR must include provisions for more frequent PCP changes with good cause. The policies and procedures shall include a definition of good cause as well as the procedures to request a change.
- (g) If a member requests assignment to a PCP located outside the distance/time requirements in Attachment III and the CONTRACTOR has PCPs available within the distance/time requirements who accept new members, it shall not be considered a violation of the access requirements for the CONTRACTOR to grant the member's request. However, in such cases the CONTRACTOR shall have no responsibility for providing transportation for the member to access care from this selected provider, and the CONTRACTOR shall notify the member in writing as to whether or not the CONTRACTOR will provide transportation for the member to seek care from the requested provider. In these cases, the CONTRACTOR must allow the member to change assignment to a PCP within the distance/time requirements at any time if the member requests such a change.

2-4.1.2 Specialty Services Providers

- a. Essential Hospital Services and Centers of Excellence
 - (1) The CONTRACTOR shall demonstrate sufficient access to Essential Hospital Services which means that, at a minimum, in each Grand Region served by the CONTRACTOR, the CONTRACTOR shall demonstrate a contractual arrangement with at least one (1) tertiary care center for each of the following:
 - (i) neonatal services;
 - (ii) perinatal services;
 - (iii) pediatric services;

- (iv) trauma services; and
- (v) burn services.

- (2) The CONTRACTOR shall demonstrate sufficient access to comprehensive care for people with HIV/AIDS which means that, at a minimum, in each Grand Region in which the CONTRACTOR operates, the CONTRACTOR shall demonstrate a contractual arrangement with at least two (2) HIV/AIDS Centers of Excellence located within the CONTRACTOR's approved Grand Region(s). HIV/AIDS centers of Excellence are designated by the DOH. The CONTRACTOR shall demonstrate a contractual arrangement with all Centers of Excellence for children in, or at risk of state custody, as identified by TennCare. This minimum requirement is not intended to release the CONTRACTOR from the requirement to provide or arrange for the provision of any covered service required by its enrollees, whether specified above or not.

b. Physician Specialists

The CONTRACTOR shall establish and maintain a network of physician specialist that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the health care needs of its members (adults and children) without excessive travel requirements. This means that, at a minimum:

- (1) The CONTRACTOR has signed provider agreements with providers of the specialty types listed in Attachment IV who accept new TennCare enrollees and are available on at least a referral basis; and
- (2) The CONTRACTOR is in compliance with the access and availability requirements in Attachments III, and IV.

(c) TENNCARE Monitoring

TENNCARE will monitor CONTRACTOR compliance with specialty network standards on an ongoing basis. TENNCARE will use data from the monthly Provider Enrollment File required in Section 2-10.c.1, to verify compliance with the specialty network requirements. TENNCARE will use these files to confirm the CONTRACTOR has a sufficient number and distribution of physician specialists and in conjunction with MCO enrollment data to calculate member to provider ratios. TENNCARE will also periodically phone providers listed on these reports to confirm that the provider is a contract provider as reported by the CONTRACTOR. TENNCARE shall also monitor appeals data for indications that problems exist with access to specialty providers.

- (1) TENNCARE will require a corrective action plan from the CONTRACTOR when:
 - (i) Twenty-five percent (25%) or more of non-dual members do not have access to one or more of the physician specialties listed in Attachment IV within sixty (60) miles;
 - (ii) Any non-dual member does not have access to one or more of the physician specialties listed in Attachment IV within ninety (90) miles; or
 - (iii) The member to provider ratio exceeds that listed in Attachment IV.
- (2) TENNCARE will review all corrective action plans and determine, based on the actions proposed by the CONTRACTOR, appeals data, and the supply of specialty providers available to non-TennCare members, whether the corrective action plan will be accepted. Corrective action plans shall include, at a minimum, the following:

- (i) The addition of contract providers to the provider network as documented on the provider enrollment file that resolves the specialty network deficiency;
- (ii) A list of providers with name, location, and expected date of provider agreement execution with whom the CONTRACTOR is currently negotiating a provider agreement and, if the provider becomes a contract provider would resolve the specialty network deficiency;
- (iii) For those deficiencies that are not resolved, a detailed account of attempts to secure an agreement with each provider that would resolve the deficiency. This shall include the provider name(s), address(es), date(s) contacted, and a detailed explanation as to why the CONTRACTOR is unable to secure an agreement, e.g., lack of provider willingness to participate in the TennCare program, provider prefers to limit access to practice, or rate requests are inconsistent with TennCare actuarial assumptions;
- (iv) A listing of non-contract providers, including name and location, who are being used to provide the deficient specialty provider services and the rates the CONTRACTOR is currently paying these non-contract providers;
- (iv) Affirmation that transportation will be provided for members to obtain services from providers who are willing to provide services to members but do not meet the specialty network standards;
- (v) Documentation of how these arrangements are communicated to the member; and
- (vi) Documentation of how these arrangements are communicated to the PCPs.

(d) **Weight Watchers**

The CONTRACTOR shall include in its network the Weight Watchers regional center in the Grand Region(s) in which the CONTRACTOR operates.

8. Section 2-6.2.c.2 shall be deleted and replaced as follows:

2-6.2.c.2. Quarterly Newsletters

- (a) **General Newsletter.** The CONTRACTOR shall, at a minimum, distribute on a quarterly basis a newsletter to all enrollees which is intended to educate the enrollee to the managed care system, proper utilization of services, etc., and encourage utilization of preventive care services. The CONTRACTOR shall include the following information in each newsletter:
 - (1) specific articles or other specific information as described when requested by TENNCARE. Such requests by TENNCARE shall be limited to two hundred (200) words and shall be reasonable including sufficient notification of information to be included; and
 - (2) the procedure on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free;
 - (3) a notice to enrollees of the right to file a complaint, as is provided for by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, the Omnibus Budget Reconciliation Act of 1981 (P.E.. 97-35), and a Contractor phone number for doing so. The notice shall be in English and Spanish;

- (4) for TennCare enrollees, EPSDT information, including but not limited to, encouragement to obtain screenings and other preventive care services;
 - (5) member services toll free telephone numbers; including the TennCare Hotline, the CONTRACTOR's customer service line and the CONTRACTOR's 24/7 Nurse Triage Line as well as the service/information that may be obtained from each line; and
 - (6) the following information to report fraud: "To report fraud or abuse to OIG: You can call free 1-800-433-3982 OR Go online at www.state.tn.us/tennCare and click on "Report Fraud." To report provider fraud or patient abuse to MFCU, call free 1-800-433-5454."
- (b) Teen/Adolescent Newsletter. The CONTRACTOR shall, at a minimum, distribute on a quarterly basis a newsletter to all enrollees between the ages of 15 and 20 which is intended to educate the enrollee to the managed care system, proper utilization of services, etc., with an emphasis on the encouragement to utilize TENNderCare services.

The Teen/Adolescent Newsletter shall be a product of the MCO Adolescent Well-Care Collaborative. The MCOs will agree on five required topics to include in each newsletter. MCOs may include additional articles at their discretion; no deviation from the five agreed upon articles will be allowed unless approved by TENNCARE.

The CONTRACTOR shall include the following information in each newsletter:

- (a) Five teen/adolescent specific articles as agreed upon by the MCO Adolescent Well Care Collaborative; and
- (b) The procedure on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free; and
- (c) TENNderCare information, including but not limited to, encouragement to obtain screenings and other preventive care services.

In order to satisfy the requirement to distribute the quarterly newsletters to all enrollees, it shall be acceptable to mail one (1) quarterly newsletter to each address associated with the enrollee's TennCare case number. In addition to the prior authorization requirement regarding dissemination of materials to enrollees, the CONTRACTOR shall also submit to TENNCARE, five (5) final printed originals, unless otherwise specified by TENNCARE, of the newsletters and documentation from the MCO's mail room or outside vendor indicating that the newsletters were mailed within the calendar quarter, the quantity, and the date mailed, to TennCare as proof of compliance by the 30th of the month following each quarter in accordance with the reporting schedules as described in Section 6-8 of this Agreement.

9. Section 2-7.1.b shall be amended by deleting and replacing "Monitoring of outcomes." In Section 2-7.1.b(1)(e) with "Program Evaluation." and adding a new Section 2-7.1.b (7) and (8) which shall read as follows:

b. MCO Case Management

- (1) The CONTRACTOR shall maintain an MCO case management program that includes the following components:
 - (a) A systematic approach to identify eligible members;
 - (b) Assessment of member needs;
 - (c) Development of an individualized plan of care;
 - (d) Implementation of the plan of care, including coordination of care that actively links the member to providers and support services; and
 - (e) Program Evaluation.

- (7) The CONTRACTOR shall submit a quarterly case management report in a format prescribed by TENNCARE. Enrollees who are enrolled in Disease Management need not be included in this report unless they are also receiving case management services.
- (8) By August 15, 2007, the CONTRACTOR will submit a report to TENNCARE describing the CONTRACTOR's case management services. The report will include a description of the criteria and process the CONTRACTOR uses to identify members for case management, the process the CONTRACTOR uses to inform members and providers of the availability of case management, a description of the case management services provided by the CONTRACTOR and the methods used by the CONTRACTOR to evaluate its case management program. Annually thereafter, the CONTRACTOR shall submit a report outlining any changes to the case management program, along with justification for such changes. These reports should only contain case management activity.

10. Section 2-7.1.e shall be deleted and replaced as follows:

2-7.1.e Excessive and/or Inappropriate Emergency Department (ED) Utilization. The CONTRACTOR shall utilize the following guidelines in identifying and managing care for enrollees who are determined to have excessive and/or inappropriate ED utilization.

- (1) Review ED utilization data, at a minimum, every six (6) months (in January and July) to identify enrollees with utilization exceeding a threshold defined by TENNCARE in the preceding six (6) month period. In January, review ED utilization during the preceding April through September. In July review ED utilization during the preceding October through March. A report shall be submitted to TENNCARE no later than February 28th and August 31st each year identifying enrollees who exceeded the defined threshold for ED usage and specifying the interventions initiated for each enrollee.
- (2) Enroll in active case management – (Enrollees who exceed a specified number, to be defined by TENNCARE, of ED visits in the previous six (6) month period)
- (3) Make contact with enrollee and primary care provider
- (4) Review encounter data
- (5) Assess most likely cause of problem (e.g., drug seeking behavior, primary care/access problem, poorly controlled disease state, etc.)
- (6) Develop a case management plan based on results of the assessment. Sample plans based on potential assessment results follow:
 - (a) Drug seeking behavior
 - i. Interact with TennCare Pharmacy Division regarding possibility of pharmacy lock-in and/or controlled substance prior authorization requirement
 - ii. Contact all providers regarding concern that patient may be abusing prescription medications
 - iii. Make appropriate referrals (e.g., OIG, Pain clinic, Substance abuse treatment program, etc.)
 - iv. Consider primary care provider lock-in (i.e. patient must have PCP approval before he/she can access other providers)
 - (b) Primary Care /Access Problem
 - i. Change PCP and/or address problem with current PCP
 - ii. Provide enrollee education regarding appropriate use of PCP and ED
 - iii. Provide access to a 1-800 customer service line for assistance identifying and selecting a PCP and to the extent necessary, assistance scheduling an appointment with PCP
 - (c) Poorly controlled disease
 - i. Enroll in disease management
 - ii. Refer to specialist for management – advise PCP
 - iii. Provide access to 1-800 24/7 nurse answered line capable of providing health information/education to patients; healthcare counseling/telephone triage to assess health status to steer patients to the appropriate level of care. The 24/7

Nurse Triage line shall assure effective patient management by avoiding over-utilization in inappropriate settings.

- (7) Any blanket policy to deny payment for specified "non-emergency" services in the ED based on diagnoses must be accompanied by the following guidelines.
- (1) Clear communication to all hospitals/EDs regarding the diagnoses that are and are not considered emergencies;
 - (2) A process whereby the hospital could demonstrate that a condition on the list did, in fact, represent an emergency;
 - (3) Clear communication to all hospitals/EDs regarding the mechanism to bill for the EMTALA required screen associated with any non-emergency diagnoses;
 - (4) Payment for the EMTALA screens associated with any non-emergency diagnosis, and
 - (5) A specific process that the MCO shares with all hospitals/EDs by which the ED can contact the MCO 24/7 to refer an enrollee with one of the non-emergency diagnoses to the MCO for assistance in arranging for care in an alternative setting, when such assistance is requested by the member.
 - (8) For hospitals that have elected to refer patients with non-urgent/emergent conditions to alternative settings for treatment, the MCO must have a specific process in place whereby the ED can contact the MCO 24/7 via a toll free phone line to obtain assistance for enrollees with non-urgent/emergent conditions who do not require inpatient admission and who are requesting assistance in scheduling an appointment in an alternate treatment setting. The CONTRACTOR may use the 24/7 Nurse Triage line described at Section 2-9.3.8 of this Agreement for this purpose or may use another line the CONTRACTOR designates. By August 1, 2007, the CONTRACTOR must submit a written report to TENNCARE providing the telephone number that will be used for such scheduling assistance and describing the process the CONTRACTOR will use to assure all requests are responded to appropriately, including a description of the training provided to staff answering the 24/7 scheduling assistance line. (9) If the CONTRACTOR chooses to implement a blanket policy as identified in subsection (7) above, failure to comply with the ED guidelines as described therein may result in liquidated damages as described in Section 6-8.b.2 of this Agreement.
 - (10) The CONTRACTOR shall track and report on a quarterly basis, the total number of calls received pertaining to patients in EDs needing assistance in accessing care in an alternative setting. Such report will include the date and time of the call, identifying information for the enrollee, the name and location of the hospital, the ultimate response to the call (e.g. appointment made with PCP) and the elapsed time from ED visit until appointment in alternative setting. If the CONTRACTOR uses the Nurse Triage line to provide appointment assistance to non-emergency ED patients, the aforementioned information may be provided in conjunction with the report discussed at Section 2-9.3.8 of this Agreement.

11. Section 2-7.1.f(5) shall be deleted and replaced as follows:

(5) CONTRACTOR's Program Description

The CONTRACTOR shall submit a description of its Disease Management Program on an annual basis in accordance with Section 2-10.13.7(b).

12. Section 2-7.1.f(8) shall be deleted and replaced as follows:

(8) Program Evaluation (Satisfaction and Effectiveness)

The CONTRACTOR shall evaluate member satisfaction with the DM services (as described by NCQA) by systematically analyzing feedback from members and analyzing member complaints and inquiries at least annually. The feedback on satisfaction must be specific to DM programs. A written summary, of member satisfaction with the DM program, shall be included in the annual DM report.

The CONTRACTOR shall establish measurable benchmarks and goals for each DM program and shall evaluate the programs using these benchmarks and goals. These benchmarks and goals shall be specific to each condition but should include the following information. This information shall be reported to TENNCARE annually on July 1st in accordance with Section 2-10.13.7.

1. The total number of active enrollees having one or more of the diagnosis codes (ICD-9 Codes) relating to each of the required DM programs;
2. The passive participation rate (as defined by NCQA) for each of the required DM programs, including the numerator and denominator used in calculating the rate
3. The number of individuals participating in each level or stratification of each of the DM programs;
4. Performance measured against at least two important aspects of the clinical practice guidelines associated with each DM program;
5. The rate of emergency department utilization and inpatient hospitalization for members with diabetes, asthma and congestive heart failure (rate calculations must be shown);
6. Neonatal Intensive Care Unit (NICU) days for births associated with members enrolled in the Maternity Management Program;
7. HEDIS measures related to any of the four DM projects;
8. Member adherence to treatment plans;
9. Provider adherence to the guidelines; and
10. Any other performance measure associated with any of the four DM programs that the MCO has chosen to track.

13. Section 2-7.1.g shall be deleted and replaced as follows:

- g. Disease Management for Obesity. In addition to the aforementioned disease management requirements, the CONTRACTOR shall have a DM program for obesity that is provided as a cost effective alternative service (see Section 2-3.10). This DM program shall, at a minimum, fulfill all requirements related to the TennCare Partnership with Weight Watchers program. This means that, at a minimum, the CONTRACTOR shall have provider agreements with the appropriate Weight Watchers regional center(s); educate its contract providers about the program to ensure they make appropriate referrals for members; and process claims according to the requirements in Section 2-9.12.

14. Section 2-9.3.8 shall be amended by adding additional text to the end of existing text.

- 2-9.3.8. The CONTRACTOR shall maintain a 1-800 Nurse Triage line that shall be available to members 24 hours a day, seven days a week. The 24/7 Nurse Triage line service shall provide health information/education to patients; healthcare counseling/telephone triage to assess health status in order to steer patients to the appropriate level of care. The 24/7 Nurse Triage line shall assure effective patient management by avoiding over-utilization in inappropriate settings. The CONTRACTOR shall include information on the Nurse Triage line, including the telephone number and the services/information available by calling the line, in the member handbook and in quarterly member newsletters. The CONTRACTOR shall track and report on a quarterly basis total calls received by the 24/7 Nurse Triage line including the ultimate disposition of the call (e.g. education only, no referral for care; referred to primary care provider for care, referred to emergency department for care). If the CONTRACTOR uses the 24/7 nurse line to fulfill the requirements set forth in Section 2-7.1.e (8) of this Agreement, such calls must be separately delineated in the report in accordance with the requirements described in Section 2-7.1.e (10) of this Agreement.

15. Section 2-9.8.2 and 2-9.8.3 and 2-9.8.7 shall be deleted and replaced as follows:

2-9.8.2. Clinical and Service Quality Improvement/Performance Improvement Activities

The CONTRACTOR shall perform three (3) clinical and two (2) service quality improvement activities relevant to the enrollee population. These Quality Improvement Activities may be used to meet NCQA

requirements if applicable. Two of the three clinical activities shall be determined by TENNCARE. The TENNCARE selected clinical quality improvement activity topics are diabetes and maternity management. The following must be documented for each activity and CMS protocols for performance improvements projects (PIPs) must be met:

- Rationale for selection as a quality improvement activity
- Specific population targeted, include sampling methodology if relevant
- Metrics to determine meaningful improvement and baseline measurement
- Specific interventions (enrollee and provider)
- Relevant clinical practice guidelines
- Date of re-measurement

The CONTRACTOR shall electronically submit Quality Improvement Activity Forms as required by NCQA. These forms are available at www.NCQA.org.

2-9.8.3. Clinical Practice Guidelines

The CONTRACTOR shall select at least four (4) evidence-based clinical practice guidelines from recognized sources that are relevant to the enrollee population. Guidelines must be distributed to all appropriate providers. The MCO shall measure performance against at least two (2) important aspects of each of the four (4) clinical practice guidelines annually. The guidelines must be reviewed and any revisions distributed to appropriate providers at least every two (2) years or whenever national guidelines change. The CONTRACTOR must submit the names of the clinical guidelines (ADA, AMA, etc.) along with a report on the results of performance measures utilized for each.

2-9.8.7 NCQA Accreditation

NCQA Accreditation must be achieved by December 31, 2006 and maintained thereafter. In order to assure that the CONTRACTOR is making forward progress, TENNCARE shall require the following information and/or benchmarks be met:

EVENT	REQUIRED DEADLINE
CALENDAR YEAR 2005	
Submit preliminary HEDIS data to EQRO as required by the CRA	July 1, 2005
Submit locked DST to NCQA	July 15, 2005
Purchase NCQA ISS Tool for 2006 MCO Accreditation Survey	August 1, 2005
Utilize the NCQA approved Quality Improvement Activity Form to submit baseline data, barrier analysis, and planned interventions for three (3) Clinical and two (2) Service Improvement Studies selected by MCO.	September 15, 2005
NCQA Accreditation Survey Application Submitted and Pre Survey Fee paid	November 15, 2005
Copy of signed contract with NCQA approved vendor to perform 2006 CAHPS Survey to TENNCARE	November 15, 2005
Copy of signed contract with NCQA approved vendor to perform 2006 HEDIS Audit to TENNCARE	November 15, 2005
Submit copy of signed NCQA Survey Contract to TENNCARE	December 15, 2005
Notify TennCare of date for ISS Submission and NCQA Onsite review	December 31, 2005
CALENDAR YEAR 2006	
HEDIS Baseline Assessment Tool completed and submitted to Contracted HEDIS Auditor and TennCare	February 15, 2006
Audited Medicaid HEDIS and CAHPS results submitted to NCQA and TennCare	June 15, 2006
Finalize preparations for NCQA Survey (final payment must be submitted to NCQA 60 days prior to submission of ISS.	July 1 – September 15, 2006
Submit ISS to NCQA	No later than

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	September 18, 2006
NCQA Survey Completed and copy of NCQA Final Report to TennCare:	December 31, 2006
<ul style="list-style-type: none"> • Excellent, Commendable, or Accredited • Provisional – Corrective Action required to achieve status of Excellent, Commendable, or Accredited; resurvey within 12 months. Plan of Corrective Action addressing deficiencies noted by NCQA to TennCare within thirty (30) days of receipt of Final Report from NCQA. Provisional status may result in the assessment of liquidated damages or termination of this Agreement. • Accreditation Denied – Results in termination of this Agreement 	
CALENDAR YEAR 2007	
Complete NCQA Reconsideration Process (if necessary)	January 1, 2007- March 30, 2007
Complete Provisional NCQA Accreditation Resurvey NOTE: Provisional NCQA Accreditation may result in the assessment of liquidated damages or termination of this Agreement	December 31, 2007
Maintain NCQA Accreditation	On-going
Audited Medicaid HEDIS and CAHPS results submitted to NCQA and TennCare	June 15, 2007
Notify TENNCARE of any revision to accreditation status based HEDIS score	Annually immediately upon notification by NCQA
CALENDAR YEAR 2008	
Maintain NCQA Accreditation	On-going
Audited Medicaid HEDIS and CAHPS* results submitted to NCQA and TennCare and the EQRO	June 15, 2008
Notify TENNCARE of any revision to accreditation status based HEDIS score	Annually immediately upon notification by NCQA

* Annually, the CONTRACTOR shall conduct a CAHPS survey. The CONTRACTOR shall enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys. The CONTRACTOR's vendor shall perform the CAHPS adult survey, CAHPS child survey and the CAHPS children with chronic conditions survey. Survey results shall be reported to TennCare, separately for each required CAHPS survey

The CONTRACTOR may obtain additional payments for the successful achievement of NCQA Accreditation as described in Section 5-1.h of this Agreement.

If the CONTRACTOR consistently fails to meet the timelines as described above, the CONTRACTOR shall be considered to be in breach of the terms of this Agreement and may be subject to termination in accordance with Section 6-2.2 of this Agreement. Further, failure to achieve specified benchmarks or reporting requirements, as described in Section 6-8.2.2 shall result in damages as described therein.

Failure to obtain NCQA Accreditation by December 31, 2006 and maintain Accreditation thereafter, shall be considered a breach of this Agreement and shall result in termination of this Agreement in accordance with the terms set forth in Section 6-2.2 of this Agreement. Achievement of Provisional accreditation status shall require a corrective action plan and may result in termination of this Agreement.

Following accreditation or re-accreditation, the CONTRACTOR must submit a copy of the bound report from NCQA" within 10 days of receipt of the report. The report from the accreditation process conducted in 2006 will be within 10 days of signature of this Agreement or within 10 days of receipt from NCQA which ever occurs later.

16. Section 2-9.13.6(c)(3) shall be amended by adding additional text as follows:

- (3) Emergency Room Utilization. The CONTRACTOR shall maintain a procedure to identify and evaluate enrollee emergency room utilization by PCP panel and provide a report to TENNCARE as described in Section 2-10.14.2 of this Agreement. Individual enrollees who establish a pattern of accessing emergency room services should be room services should be referred to case management for follow-up.

17. Section 2-10.3.1 shall be amended by adding additional text as follows:

2-10.3.1. Monthly Provider Enrollment File

The CONTRACTOR shall furnish to TENNCARE at the beginning of the Agreement period an electronic report in the format specified by TENNCARE listing all providers enrolled in the TennCare plan, including but not limited to, physicians, dentists, hospitals, home health agencies, pharmacies, medical vendors, ambulance, etc. This listing shall include regularly enrolled providers, specialty or referral providers and any other provider, which may be enrolled for purposes of payment for services provided out-of-plan. The minimum data elements required for all provider listings required in this Section may be found in Attachment XII, Exhibit C of this Agreement. The CONTRACTOR shall be required to inquire as to the provider's race and/or national origin and shall report to TENNCARE the information, if any, furnished by the provider in response to such an inquiry. The CONTRACTOR shall be prohibited from requiring the provider to declare race and/or national origin and shall not utilize information regarding race or national origin obtained pursuant to such request as a basis for decisions regarding participation in the CONTRACTOR's provider network or in determination of compensation amounts.

Thereafter, a complete electronic provider replacement file (full file refresh) shall be submitted on a monthly basis by the 5th of each month. This information shall be used to determine CONTRACTOR compliance with network adequacy standards and shall be used in conjunction with encounter data.

Each provider shall be identified by a Tennessee Medicaid I.D. number (i.e., each servicing provider in a group or clinic practice must be identified by a separate provider number) as well as the National Provider Identifier (NPI) Number, effective May 23, 2007. These unique identifiers shall appear on all encounter data transmittals.

Within ten (10) working days of a request by TENNCARE, the CONTRACTOR shall provide an unduplicated listing of all contracting providers, in a format designated by TENNCARE.

Failure to report the provider information, as specified above, shall result in the application of liquidated damages as described in Section 6-8.2 of this Agreement.

18. Section 2-10.5.4 shall be deleted in its entirety.

19. Section 2-10.10.7 shall be amended by adding additional text as follows:

2-10.10.7 High-Cost Claimants

The CONTRACTOR shall identify and report to TennCare the number of enrollees who incurred claims in excess of twenty-five thousand dollars (\$25,000) on a rolling quarterly basis. The CONTRACTOR shall report the enrollee's age, sex, primary diagnosis, and amount paid by claim type for each enrollee. The name, and other identifying information of the member shall be blinded in order to maintain confidentiality.

Amendment 17 (cont.)

20. Section 2-10.13.3 shall be deleted and replaced as follows:

2-10.13.3. PCP Assignment

The CONTRACTOR shall submit a quarterly report to TENNCARE by PCP that shall include the following information for non-dual populations: Provider Name, Provider Medicaid I.D. Number, NPI Number, Number of Enrollees assigned by Enrollee Age Category. The enrollee age categories shall be consistent with the following; Age Under 1, Age 1 – 13, Age 14 – 20, Age 21- 44, Age 45 – 64, Age 65 +.

21. Section 2-10.13.7 shall be deleted and replaced as follows:

2-10.13.7. Disease Management Evaluation

- (a) The CONTRACTOR shall submit a quarterly *Disease Management Update Report* that includes, for each disease management program as described in Section 2-7.1.f, a brief narrative description of the program, the total number of members in the program, the total number of members enrolled and disenrolled during the quarter, and a description of the specific provider and member interventions performed during the quarter. The report shall be submitted in a format prescribed by TENNCARE.
- (b) Annually on July 1st, the CONTRACTOR shall submit a *Disease Management Report* that includes, the following:
 - (1) Definition of target population (eligibility criteria) for each program and the method used to identify and enroll members including frequency of systematic identification process;
 - (2) Written description of the stratification levels for each of the four (4) programs , including member criteria and associated interventions;
 - (3) Information specified in 2-7.1.f (7);
 - (4) Written analysis of data presented;
 - (5) Discussion of barriers and challenges to include resources, program structure, member involvement and provider participation;
 - (6) Summary of member satisfaction with the DM program; and
 - (7) Description of proposed changes to program based on evaluation.

22. Section 2-10.13. shall be amended by adding a new Section 2-10.13.9 which shall read as follows:

2-10.13(9) Case Management Reporting

- (1) The CONTRACTOR shall submit a quarterly case management report in a format prescribed by TENNCARE. Enrollees who are enrolled in Disease Management need not be included in this report unless they are also receiving case management services.
- (2) By August 15, 2007, the CONTRACTOR will submit a report to TENNCARE describing the CONTRACTOR's case management services. The report will include a description of the criteria and process the CONTRACTOR uses to identify members for case management, the process the CONTRACTOR uses to inform members and providers of the availability of case management, a description of the case management services provided by the CONTRACTOR and the methods used by the CONTRACTOR to evaluate its case management program. Annually thereafter, the

Amendment 17 (cont.)

CONTRACTOR shall submit a report outlining any changes to the case management program, along with justification for such changes. These reports should only contain case management activity.

23. Section 2-10.14.2 shall be deleted and replaced as follows:

2-10.14.2 Emergency Room Utilization

As specified in Sections 2-7.1.e and 2-9.4, the CONTRACTOR shall maintain a procedure to identify enrollees by PCP panel who establish a pattern of use of the emergency room and shall submit the following reports regarding Emergency Room/Emergency Department Utilization.

- (a) The CONTRACTOR shall submit a monthly report by PCP that includes the following information: Provider Name, Provider Medicaid I.D. Number, NPI Number, Provider Specialty, Number of Members assigned, and Number of ER Visits. This report shall include a rolling twelve (12) months which shall be refreshed on a monthly basis and submitted with a thirty (30) day lag. Each monthly report is due to TENNCARE by the 5th calendar day of the following month.
- (b) In accordance with Section 2-7.1.e, the CONTRACTOR shall submit to TENNCARE the following Emergency Department Utilization Reports:
 - (1) No later than February 28th and August 31st each year, submit a report identifying enrollees who exceeded the defined threshold for ED usage and specifying the interventions initiated for each enrollee.
 - (2) By August 1, 2007, the CONTRACTOR must submit a written report to TENNCARE providing the telephone number that will be used for such scheduling assistance and describing the process the CONTRACTOR will use to assure all requests are responded to appropriately, including a description of the training provided to staff answering the 24/7 scheduling assistance line.
 - (3) On a quarterly basis, the CONTRACTOR shall report the total number of calls received pertaining to patients in EDs needing assistance in accessing care in an alternative setting. Such report will include the date and time of the call, identifying information for the enrollee, the name and location of the hospital, the ultimate response to the call (e.g. appointment made with PCP) and the elapsed time from ED visit until appointment in alternative setting. If the CONTRACTOR uses the Nurse Triage line to provide appointment assistance to non-emergency ED patients, the aforementioned information may be provided in conjunction with the report discussed at Section 2-9.3.8 of this Agreement.

24. Section 2-10.14 shall be amended by adding a new 2-10.14.4 which shall read as follows:

2-10.14.4 24/7 Nurse Triage Call Line

In accordance with Section 2-9.3.8 of this Agreement, the CONTRACTOR shall track and report on a quarterly basis total calls received by the 24/7 Nurse Triage line including the ultimate disposition of the call (e.g. education only, no referral for care; referred to primary care provider for care, referred to emergency department for care). If the CONTRACTOR uses the 24/7 nurse line to fulfill the requirements set forth in Section 2-7.1.e (8) of this Agreement, such calls must be separately delineated in the report in accordance with the requirements described in Section 2-7.1.e (10) of this Agreement.

25. Section 2-28.b and 2-28.c shall be deleted and replaced as follows:

- b. Community Health Record Deliverables. Effective July 1, 2005, version 1.0 of the CHR shall be available to TENNCARE for VSHP contracted providers and all enrollees assigned to BlueCare/TennCare Select.

Enrollees may opt out in which case the enrollee's information will be omitted from view through the CHR. The CHR shall include the following enrollee information:

- Patient Demographics
- Primary Care Physicians (PCPs) identified
- Claimed visit information from claims detail
- Medication information from claims detail
- State immunization information
- Laboratory results and/or Laboratory data information from claims detail
- Interactivity by the provider through EPSDT (TenderCare) documentation to include 16 age specific forms complying with current periodicity

c. Community Health Record Electronic Prescribing Function

Beginning no later than October 31, 2005, as a component of the Community Health Record function of TennCare Select, the Contractor shall begin making available to VSHP contracted providers the following electronic prescribing functionality to allow for prescribing medications:

- Eligibility
- Formulary information
- Drug to drug compatibility
- Drug to allergy checking
- Dose range checking based on predetermined characteristics including age, height, weight and additional attributes
- Member and provider education as regards co-pays and total costs differentials for brand names versus generic utilization
- Appropriate therapeutic substitution
- Step care progression relevant to clinical process

Effective no later than September 1, 2006, VSHP began making available the current version of the Community Health Connection to all TennCare providers for the entire TennCare population, with the exception of enrollees who opt out, not to exceed 1.3 million members. In addition, VSHP commenced comprehensive communication, marketing and outreach programs to providers to maximize the number of providers who utilize the Shared Health System. VSHP initially targeted a 10% provider adoption rate by TennCare providers no later than nine (9) months following the implementation of all TennCare enrollees of 3rd Quarter 2006; 16% in Year 2 and 25% in Year 3.

Further requirements, including but not limited to, timeframes and procedural requirements are provided for in the Memorandum of Understanding (MOU) between the State, VSHP and Shared Health. Said requirements, guidelines and expectations, including but not limited to liquidated damages, are incorporated by reference, as though copied verbatim, herein.

26. Section 4-1.1.n shall be amended by adding new text in the last paragraph so that the amended Section 4-1.1.n shall read as follows:

- n. It is the intent and policy of TENNCARE that TennCare-eligible newborn children and their TennCare eligible mothers, be enrolled in the same MCO. This policy is only applicable to Group 6 enrollees. Enrollment of the newborn child in the same plan as its Mother facilitates coverage and payment of the costs associated with delivery, facilitates coverage and payment of the newborn services provided after birth of the child but prior to establishment of individual TennCare eligibility for the child and provides a financial incentive to the CONTRACTOR to promote prenatal care as a means to reduce the risks of a complicated and more costly pregnancy and/or delivery.

It is recognized by TENNCARE and the CONTRACTOR that despite the best efforts of TENNCARE to assure enrollment of a newborn in the same plan as its Mother, due to the various means of enrollment in

the TennCare program, a newborn child may be inadvertently enrolled in a plan different than its Mother. When such cases are identified by the CONTRACTOR, the CONTRACTOR shall immediately report to TENNCARE, in accordance with written procedures provided by TENNCARE, that a newborn child has been incorrectly enrolled in a plan different than its Mother. Upon receipt of such notice from a CONTRACTOR or discovery by TENNCARE that a newborn has been incorrectly enrolled in a plan different than its Mother, TENNCARE shall immediately:

- (1) Disenroll the newborn from the incorrect plan;
- (2) Recoup any payments made to the CONTRACTOR for the newborn;
- (3) Enroll the newborn in the same plan as its Mother with the same effective date as when the newborn child was enrolled in the incorrect plan; and
- (4) Make payments to the correct plan for the period of coverage.

The plan in which the newborn child is correctly enrolled shall be responsible for the coverage and payment of TennCare-covered services provided to the newborn child for the full period of eligibility. The plan in which the newborn child was incorrectly enrolled shall have no liability for the coverage or payment of any TennCare-covered services provided, except as described below, during the period of incorrect plan assignment and TENNCARE shall have no liability for payments to the CONTRACTOR in these cases.

There are circumstances in which a newborn child's Mother may not be eligible for participation in the TennCare program. The CONTRACTOR shall be required to process claims received for services provided to newborn children within the time frames specified in Section 2-9.7 of this Agreement. The CONTRACTOR shall not utilize any blanket policy which results in the automatic denial of claims for services provided to a TennCare-eligible newborn child, during any period of enrollment in the CONTRACTOR's plan, because the child's Mother is not a member of the CONTRACTOR's plan. However, it is recognized that in complying with the claims processing time frames specified in Section 2-9.7 of this Agreement, the CONTRACTOR may make payment for services provided to a TennCare-eligible newborn child enrolled in the CONTRACTOR's plan at the time of payment but the child's eligibility may subsequently be moved to another contractor's plan. In such event, the CONTRACTOR in which the newborn child is first enrolled (first plan) may submit supporting documentation to the contractor's plan in which the newborn child is moved (second plan) and the second plan shall reimburse the first plan within thirty (30) days of receipt of such properly documented request for reimbursement, for the amount expended on behalf of the child prior to the child's eligibility having been moved to the second plan. Such reimbursement shall be the actual amount expended by the CONTRACTOR and shall be used to reduce the amount of funds requested from the State in the weekly remittance request. In the event the CONTRACTOR is the second plan (i.e. the plan to which the newborn child is moved), should the CONTRACTOR fail to reimburse the first plan the actual amount expended on behalf of the newborn child within thirty (30) days of receipt of a properly documented request for payment, TENNCARE is authorized to reimburse the first plan. In the event that the CONTRACTOR fails to reimburse the first MCO the actual amount expended on behalf of the newborn within thirty (30) calendar days of receipt of a properly documented request for payment, TENNCARE may assess liquidated damages as specified in Section 6-8.b.2.

27. Section 5-1.i and j. shall be deleted and replaced as follows:

- i. Effective July 1, 2005 through August 31, 2006, VSHP shall provide all services required to maintain the CHR, EPSDT documentation and reporting analytics as related to said CHR as defined above, at no additional charge to the TennCare Bureau. Effective July 1, 2006 through June 30, 2007, VSHP shall be reimbursed an administration fee for maintaining and providing the CHR of \$1.20 PMPM for enrollees participating in the CHR.. TENNCARE shall not reimburse the additional \$1.20 PMPM for enrollees who opt out and are omitted from the CHR. Upon sixty (60) calendar days prior written notice, the State may terminate the services to be provided under this section of this agreement with or without cause, and/or for convenience. Upon provision of said notice and at the conclusion of the sixty (60) calendar day notice period VSHP's obligation to provide necessary services to maintain the CHR will end and the State shall have no further obligation to reimburse the \$1.20 PMPM administration fee. Effective July 1, 2007, the

administration fee for providing the CHR shall be set forth in the Memorandum of Understanding (MOU) between the State, VSHP and Shared Health.

j. Pay-for-Performance Quality Incentive

On July 1, 2007 the CONTRACTOR will be eligible for an additional \$0.03 pmpm, applied to member months from the period of July 1, 2006 to December 31, 2006, if their HEDIS 2007 HbA1C testing rate demonstrates significant improvement when compared to the MCO's 2006 HEDIS HbA1C testing rate. Significant improvement is defined using NCQA's minimum effect size change methodology and is illustrated in the following table where the CONTRACTOR's 2006 HEDIS HbA1C testing rate represents the baseline.

NCQA Minimum Effect Size Change Requirements:

Baseline Rate	Minimum Effect Size
0-59	At least a 6 percentage point change
60-74	At least a 5 percentage point change
75-84	At least a 4 percentage point change
85-92	At least a 3 percentage point change
93-96	At least a 2 percentage point change
97-99	At least a 1 percentage point change

In addition, on July 1, 2007, the CONTRACTOR will be eligible for another \$0.03 pmpm applied to member months from the period of July 1, 2006 – December 31, 2006. This additional payment will be made if the CONTRACTOR's 2007 HEDIS Prenatal Care rate demonstrates significant improvement when compared to the MCO's 2006 HEDIS Prenatal Care rate. Significant improvement is defined using NCQA's minimum effect size change methodology and is illustrated in the table above where the MCO's 2006 HEDIS Prenatal Care rate represents the baseline.

On December 31, 2007, the CONTRACTOR will be eligible for an additional \$0.03 pmpm applied to member months from January 1, 2007 – June 30, 2007 if the ED visit rate per 1000 for asthma has decreased by at least 5%. The time period for comparison will be January 1, 2007 – June 30, 2007 compared to a baseline represented by January 1, 2006, - June 30, 2006. Dual eligibles will be excluded from the rate numerator and denominator. Per methodology developed by the Bureau, only ED visits with asthma as a primary diagnosis will be included in the rate numerator. The rate denominator will include individuals with asthma in any diagnosis field on any claim. Only individuals with continuous eligibility will be included in this calculation.

In addition, on December 31, 2007, the CONTRACTOR will be eligible for an another \$0.03 pmpm applied to member months from January 1, 2007 – June 30, 2007 if the ED visit rate per 1000 for congestive heart failure has decreased by at least 5%. The time period for comparison will be January 1, 2007 – June 30, 2007 compared to a baseline represented by January 1, 2006, - June 30, 2006. Dual eligibles will be excluded from the rate numerator and denominator. Per methodology developed by the Bureau, only ED visits with congestive heart failure as a primary diagnosis will be included in the rate numerator. The rate denominator will include individuals with congestive heart failure in any diagnosis field on any claim. Only individuals with continuous eligibility will be included in this calculation.

On July 1, 2008, the CONTRACTOR will be eligible for a \$0.03 pmpm payment, applied to member months from the period January 1, 2007 to December 31, 2007, for each of the following 2008 HEDIS or CAHPS measures for which significant improvement has been demonstrated. Significant improvement is defined using NCQA's minimum effect size change methodology, where the applicable 2007 HEDIS or CAHPS score serves as the baseline.

- HbA1C Testing
- Controlling High Blood Pressure
- Timeliness of Prenatal Care
- Postpartum Care
- Adolescent Immunizations (combo2)
- Childhood Immunizations (combo 2)
- Cervical Cancer Screening

28. The Liquidated Damages Chart in Section 6-8.2.2 shall be amended by adding a new C.4 which shall read as follows:

C.4	Failure to reimburse the first MCO within thirty (30) calendar days of receipt of a properly documented request for a misaligned newborn in accordance with Section 4-1.1.n		\$1000.00 per day for each day beyond thirty (30) calendar days of receipt of a properly documented request in addition to a one time assessment of \$5,000 per occurrence
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29. Section 6-27 shall be deleted and replaced as follows:

6-27 Contract Term of The Agreement

This Agreement and its incorporated attachments, if any, as well as all Amendments to this Agreement, contain all of the terms and conditions agreed upon by the parties, and when executed by all parties, supersedes any prior agreements. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall be in effect from July 1, 2001, subject to approval by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The term of this Agreement shall expire on June 30, 2008. At the mutual agreement of TennCare and the CONTRACTOR, this CONTRACT shall be renewable for an additional twelve month period.

Notwithstanding any provision herein to the contrary, the State may terminate this Agreement if the waiver governing TennCare is terminated. The documents referenced in the Agreement are on file with the CONTRACTOR and with TENNCARE and the CONTRACTOR is aware of their content. No other agreement, oral or otherwise regarding the subject matter of this Agreement, shall be deemed to exist or to bind any of the parties hereto.

30. ATTACHMENT IV shall be deleted and replaced in its entirety and shall read as follows:

ATTACHMENT IV SPECIALTY NETWORK STANDARDS

The CONTRACTOR shall adhere to the following specialty network requirements to ensure access and availability to specialists for all members (adults and children) who are not dually eligible for Medicare and TennCare (non-dual members). For the purpose of assessing specialty provider network adequacy, TENNCARE will evaluate the CONTRACTOR's provider network relative to the requirements described below. A provider is considered a "specialist" if he/she has a provider agreement with the CONTRACTOR to provide specialty services to members.

Access to Specialty Care

The CONTRACTOR shall ensure access to specialty providers (specialists) for the provision of covered services. At a minimum, this means that:

- (1) The CONTRACTOR shall have provider agreements with providers practicing the following specialties: Allergy, Cardiology, Dermatology, Endocrinology, Otolaryngology, Gastroenterology, General Surgery, Neonatology, Nephrology, Neurology, Neurosurgery, Oncology/Hematology, Ophthalmology, Orthopedics and Urology; and

(2) The following access standards are met:

- o Travel distance does not exceed 60 miles for at least 75% of non-dual members and
- o Travel distance does not exceed 90 miles for ALL non-dual members

Availability of Specialty Care

The CONTRACTOR shall provide adequate numbers of specialists for the provision of covered services to ensure adequate provider availability for its non-dual members. To account for variances in MCO enrollment size, the guidelines described in this Attachment have been established for determining the number of specialists with whom the CONTRACTOR must have a provider agreement. These are aggregate guidelines and are not age specific. To determine these guidelines the number of providers within each Grand Region was compared to the size of the population in each Grand Region. The CONTRACTOR shall have a sufficient number of provider agreements with each type of specialist in each Grand Region served to ensure that the number of non-dual members per provider does not exceed the following:

Maximum Number of Non-Dual Members per Provider by Specialty

Specialty	Number of Non-Dual Members
Allergy & Immunology	100,000
Cardiology	20,000
Dermatology	40,000
Endocrinology	25,000
Gastroenterology	30,000
General Surgery	15,000
Nephrology	50,000
Neurology	35,000
Neurosurgery	45,000
Oncology/Hematology	80,000
Ophthalmology	20,000
Orthopedic Surgery	15,000
Otolaryngology	30,000
Urology	30,000

31. Attachment XII, Exhibit E shall be deleted and replaced with "LEFT BLANK INTENTIONALLY".

**ATTACHMENT XII, EXHIBIT E
LEFT BLANK INTENTIONALLY**

32. ATTACHMENT XII, Exhibit H.1 "QIA Grid" shall be deleted in its entirety and shall read "LEFT BLANK INTENTIONALLY".

All of the provisions of the original Contract not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective July 1, 2007 or as of the date it is approved by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

BY: M.D. Goetz, Jr.
M. D. Goetz, Jr.
Commissioner

DATE: 6/19/07

VOLUNTEER STATE HEALTH PLAN, INC.

BY: Ronald E. Harr
Ronald E. Harr
President and Chief Executive Officer

DATE: _____

APPROVED BY:

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

BY: M.D. Goetz, Jr.
M. D. Goetz, Jr.
Commissioner

DATE: 6/22/07

APPROVED BY:

**STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY**

BY: John G. Morgan
John G. Morgan
Comptroller

DATE: 6-29-07

CONTRACT SUMMARY SHEET

RFS Number:	318.66-026	Contract Number:	FA-02-14632-16
State Agency:	Department of Finance and Administration	Division:	Bureau of TennCare

Contractor	Contract Identification Number
VSHP (TennCare Select)	<input type="checkbox"/> V- <input type="checkbox"/> C-

Service Description

Managed Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medicaid Population

Contract Begin Date	Contract End Date
7/1/2001	12/31/2007

Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66	4A2	134	11	<input type="checkbox"/> STARS		
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)	
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$ 18,599,868.48	
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$ 33,079,942.80	
2004	\$ 25,125,990.72	\$ 38,364,165.90			\$ 63,490,156.62	
2005	\$ 58,007,447.00	\$ 58,007,447.00			\$ 116,014,894.00	
2006	\$87,748,111.00	\$87,748,111.00			\$175,496,222.00	
2007	\$87,748,111.00	\$87,748,111.00			\$175,496,222.00	
Total:	\$281,170,720.35	\$ 301,006,585.55			\$582,177,305.90	

CFDA#	93.778 Title XIX Dept. of Health & Human Svcs.	Check the box ONLY if the answer is YES:
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State Fiscal Contract		
Name:	Scott Pierce	Is the Contractor a SUBRECIPIENT? (per OMB A-133)
Address:	310 Great Circle Road	Is the Contractor a Vendor? (per OMB A-133)
Phone:	Nashville, TN (615)507-6415	Is the Fiscal Year Funding STRICTLY LIMITED?
Procuring Agency Budget Officer Approval Signature		Is the Contractor on STARS?
Scott Pierce		Is the Contractor's FORM W-9 ATTACHED?
		Is the Contractor's Form W-9 Filed with Accounts?

COMPLETE FOR ALL AMENDMENTS (only)			Funding Certification
	Base Contract & Prior Amendments	This Amendment ONLY	Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.
CONTRACT END DATE:	12/31/2006	12/31/2007	
FY: 2002	\$ 18,599,868.48		
FY: 2003	\$ 33,079,942.80		
FY: 2004	\$ 63,490,156.62		
FY: 2005	\$116,014,894.00		
FY: 2006	\$175,496,222.00		
FY: 2007	\$103,344,344.00	\$72,151,878.00	
Total:	\$510,025,427.90	\$72,151,878.00	

RECEIVED
 2006 DEC 29 PM 1:25
 COMPTROLLER'S OFFICE
 OFFICE OF
 MANAGEMENT SERVICES

AMENDMENT NUMBER 16

AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.

CONTRACT NUMBER: FA-02-14632-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as follows:

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. The Hospice Benefit, Sitter Benefit, and Convalescent Care Benefit descriptions in Section 2-3.1.2 shall be deleted and replaced and shall read as follows:

Hospice Care	As medically necessary. Must be provided by a Medicare-certified hospice. Provided and reimbursed in accordance with state and federal requirements, including but not limited to the following: <ul style="list-style-type: none">• Rates shall be no less than the federally established Medicaid hospice rates (updated each FFY), adjusted by area wage adjustments for the categories described by CMS;• The rates described above shall be subject to the annual cap for Medicaid Hospice rates as provided annually by CMS; and• If a Medicaid hospice patient resides in a nursing facility (NF), the CONTRACTOR must pay an amount equal to at least 95 percent of the prevailing NF room and board rate to the hospice provider (not subject to the annual cap for Medicaid Hospice rates).
Sitter	Medicaid/Standard Eligible, Age 21 and older: NON COVERED Medicaid/Standard Eligible, Under age 21: Covered as medically necessary. Effective February 1, 2007, Non-Covered, unless the CONTRACTOR is otherwise notified by TENNCARE.
Convalescent Care	Medicaid/Standard Eligible, Age 21 and older: NON COVERED Medicaid/Standard Eligible, Under age 21: Covered as medically necessary. Effective February 1, 2007, Non-Covered, unless the CONTRACTOR is otherwise notified by TENNCARE.

2. Section 2-3.2 shall be deleted and replaced in its entirety and shall read as follows:

2-3.2(a) The service thresholds and the CONTRACTOR's responsibility once a non-institutionalized adult has met the threshold are as follows:

Service	Threshold for Non-Institutionalized Medicaid Eligibles, Age 21 and Older	CONTRACTOR Responsibility Once Member Has Reached Threshold
Inpatient Hospital Services	20 days per SFY	Enroll member in MCO case management or disease management program, whichever is more appropriate

3. Section 2-4.7.1 shall be amended by deleting and replacing the fourth sentence so that the amended Section 2-4.7.1 shall read as follows:

2-4.7.1. Emergency Medical Services obtained from Out of Plan Providers

The CONTRACTOR's plan shall include provisions governing utilization of and payment by the CONTRACTOR for emergency medical services received by an enrollee from non-contract providers, regardless of whether such emergency services are rendered within or outside the community service area covered by the plan. Coverage of emergency medical services shall not be subject to prior authorization by the CONTRACTOR and shall be consistent with federal requirements regarding post-stabilization services, including but not limited to, 42 CFR Section 438.114(c)(1)(ii)(A). Utilization of and payments to non-contract providers may, at the CONTRACTOR's option, be limited to the treatment of emergency medical conditions, including post-stabilization care that includes medically necessary services rendered to the enrollee until such time as he/she can be safely transported to an appropriate contract service location. Payment amounts shall be in accordance with TENNCARE rules and regulations for emergency out-of-plan services. Payment by the CONTRACTOR for properly documented claims for emergency medical services rendered by a non-contract provider shall be made within thirty (30) calendar days of receipt of a clean claim by the CONTRACTOR.

The CONTRACTOR must review and approve or disapprove claims for emergency medical services based on the definition of emergency medical services specified in Section 1-3 of this Agreement. If the CONTRACTOR determines that a claim requesting payment of emergency medical services does not meet the definition as specified in Section 1-3 and subsequently denies the claim, the CONTRACTOR shall notify the provider of the denial. This notification shall include information to the provider regarding the CONTRACTOR's process and timeframes for reconsideration. In the event a provider disagrees with the CONTRACTOR's decision to disapprove a claim for emergency medical services, the provider may pursue the independent review process for disputed claims as provided by T.C.A., Section 56-32-226, including but not limited to MCO reconsideration.

Amendment 16 (cont.)

4. Section 2-7.1.b(2) shall be amended by deleting item (b) and renumbering the remaining items.
2. The CONTRACTOR shall provide MCO case management to members who are at high risk or have unique, chronic, or complex needs. This shall include but not be limited to:
 - (a) Members who have reached the service threshold for inpatient hospital services;
 - (b) Members with co-occurring mental illness and substance abuse, and/or co-morbid physical health and behavioral health conditions;
 - (c) Members who meet the requirements at 2-3.s.5(a) regarding excessive and/or inappropriate Emergency Department Utilization; and
 - (d) Children with special health care needs unless already enrolled in an appropriate disease management program.
5. Section 2-7.1(f) shall be amended by deleting item (2) and renumbering the remaining items.

(2) Member Identification Strategies

The MCO must have a systematic method of identifying and enrolling eligible members in each DM program. This shall include but not be limited to:

- (a) Members who have reached the service threshold for inpatient hospital services (see Section 2-3.a.2).
 - (b) Members who meet the requirements at 2-3.s.5(f)(3) regarding excessive and/or inappropriate Emergency Department Utilization who could potentially benefit from enrollment in a disease management program.
 - (c) Members who have reached the service threshold for inpatient hospital services shall be enrolled in either a disease management program or MCO case management, whichever the CONTRACTOR determines is more appropriate.
6. Section 2-9.10 shall be deleted and replaced in its entirety.

2-9.10. Subrogation (Casualty) Recovery

The CONTRACTOR shall conduct diagnosis and trauma code editing to identify potential subrogation related claims. This editing should, at a minimum, identify claims with a diagnosis of 800.00 thru 999.99 (excluding 994.6) or a claim submitted with an accident trauma indicator of 'Y'. TENNCARE approved questionnaires or other type TENNCARE approved forms shall be used to gather data and information pertinent to potential subrogation cases. TENNCARE shall determine a threshold amount for which a subrogation case should be pursued. The CONTRACTOR shall develop and utilize guidelines which have been approved by TENNCARE to settle subrogation cases. The CONTRACTOR shall submit subrogation recovery guidelines to TENNCARE for review and approval by January 15th each year and prior to subsequent changes thereafter. TENNCARE shall respond to the CONTRACTOR's request within fifteen (15) calendar days of the CONTRACTOR's submission of the subrogation recovery guidelines.

7. Section 2-9.14.b.1 shall be amended by adding new text to the end of the existing text so that the amended Section 2-9.14.b.1 shall read as follows:

2-9.14.b Fraud and Abuse Compliance Plan

1. The CONTRACTOR shall have a written Fraud and Abuse compliance plan. A paper and electronic copy of the plan shall be provided to TENNCARE. The CONTRACTOR's specific internal controls and polices and procedures shall be described in a comprehensive written plan

and be maintained on file with the CONTRACTOR and submitted for review to TENNCARE within thirty (30) calendar days of the effective date of this Agreement and annually thereafter. TENNCARE shall provide notice of approval, denial, or modification to the CONTRACTOR within thirty (30) calendar days of receipt. The CONTRACTOR shall make any requested updates or modifications available for review to TENNCARE as requested by TENNCARE and/or the TennCare Program Integrity Unit within thirty (30) calendar days of a request. The State shall not transfer their law enforcement functions to the CONTRACTOR.

8. Section 2-9 shall be amended by adding a new Section 2-9.15 which shall read as follows:

2-9.15 Business Continuity and Disaster Recovery (BC-DR) Plan

- (a) Regardless of the architecture of its Systems, the CONTRACTOR shall develop and be continually ready to invoke a BC-DR plan that is reviewed and prior approved by TENNCARE. TENNCARE shall provide guidance to the CONTRACTOR regarding its BC-DR plan in a Standard Operating Procedure.
- (b) At a minimum the CONTRACTOR's BC-DR plan shall address the following scenarios:
 - (a) the central computer installation and resident software are destroyed or damaged,
 - (b) System interruption or failure resulting from network, operating hardware, software, or operational errors that compromises the integrity of transactions that are active in a live system at the time of the outage,
 - (c) System interruption or failure resulting from network, operating hardware, software or operational errors that compromises the integrity of data maintained in a live or archival system, and
 - (d) System interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system but does prevent access to the System, i.e., causes unscheduled System unavailability.
- (c) The CONTRACTOR's BC-DR plan shall specify projected recovery times and data loss for mission-critical Systems in the event of a declared disaster.
- (d) The CONTRACTOR shall periodically, but no less than annually, test its BC-DR plan through simulated disasters and lower level failures in order to demonstrate to TENNCARE that it can restore System functions.
- (e) The CONTRACTOR shall submit a baseline BC-DR plan to TENNCARE and communicate proposed modifications as required in Section 2.10.18.

9. Section 2-10.5. shall be amended by deleting and replacing Section 2-10.5.2 and adding a new 2-10.5.4.

1. TPL Reporting

- (a) Cost Avoidance Value Reporting. The CONTRACTOR shall report all claim adjustment amounts due to TPL coverage or Medicare coverage on a frequency and in a format and media described by TENNCARE. The CONTRACTOR shall calculate cost savings in categories described by TENNCARE.

4. Payment for Out-of-Plan Emergency Providers

The CONTRACTOR shall report to TENNCARE the average payment rate paid to out-of-plan emergency providers by January 31 each calendar year for the prior year.

Amendment 16 (cont.)

10. Section 2-10.14 shall be amended by adding a new 2-10.14.1 and renumbering the existing items accordingly so that the new 2-10.14.1 shall read as follows:

2-10.14.1 PCP Visits

The CONTRACTOR shall submit a quarterly *PCP Visits Per Member Per Year Report* in the format prescribed by TENNCARE. The number of PCP visits per member during the reporting quarter shall be projected to reflect a twelve (12) month period.

11. Section 2-10.18 shall be deleted and replaced so that the new Section 2-10.18 shall read as follows:

2-10.18. Business Continuity and Disaster Recovery Reports

The CONTRACTOR shall submit a high level summary of their baseline *Business Continuity and Disaster Recovery (BC-DR)* plan or make it available at CONTRACTOR's local Tennessee site for review and approval as specified by TENNCARE. The CONTRACTOR shall communicate a high level summary of proposed modifications to the BC-DR plan or make it available at CONTRACTOR's local Tennessee site at least fifteen (15) calendar days prior to their proposed incorporation. Such modifications shall be subject to review and approval by TENNCARE.

12. Section 2 shall be amended by adding a new Section 2-29 which shall read as follows:

2-29. Notice of Legal Action

The CONTRACTOR shall provide to TENNCARE and the Tennessee Department of Commerce and Insurance, TennCare Division, notice in writing by Certified Mail (or other means such as overnight delivery reasonably designed to document delivery) within five (5) business days of the CONTRACTOR being served with any administrative or legal action or complaint filed regarding any claim in law or equity made against the CONTRACTOR, or an affiliate of the CONTRACTOR (including but not limited to a parent company), that would materially impact either such affiliate's ability to operate its business or the CONTRACTOR's performance of duties hereunder. The Contractor shall also provide similar notice of any arbitration proceedings instituted between a provider and the CONTRACTOR. It is the intent of this provision that the CONTRACTOR notify TENNCARE of any and all actions described herein that may affect the CONTRACTOR'S financial viability and/or program operations or integrity.

13. Section 2 shall be amended by adding a new Section 2-30 which shall read as follows:

2-30. Prohibition of Illegal Immigrants. The requirements of Public Acts of 2006, Chapter Number 878, of the state of Tennessee, addressing the use of illegal immigrants in the performance of any contract to supply goods or services to the state of Tennessee, shall be a material provision of this Contract, a breach of which shall be grounds for monetary and other penalties, up to and including termination of this Contract.

- a. The Contractor hereby attests, certifies, warrants, and assures that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract. The Contractor shall reaffirm this attestation, in writing, by submitting to the State a completed and signed copy of the document as Attachment II, hereto, semi-annually during the period of this Contract. Such attestations shall be maintained by the contractor and made available to state officials upon request.
- b. Prior to the use of any subcontractor in the performance of this Contract, and semi-annually thereafter, during the period of this Contract, the Contractor shall obtain and retain a current, written attestation that the subcontractor shall not knowingly utilize the services of an illegal

Amendment 16 (cont.)

immigrant to perform work relative to this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant to perform work relative to this Contract. Attestations obtained from such subcontractors shall be maintained by the contractor and made available to state officials upon request.

- c. The Contractor shall maintain records for all personnel used in the performance of this Contract. Said records shall be subject to review and random inspection at any reasonable time upon reasonable notice by the State.
- d. The Contractor understands and agrees that failure to comply with this section will be subject to the sanctions of Public Chapter 878 of 2006 for acts or omissions occurring after its effective date. This law requires the Commissioner of Finance and Administration to prohibit a contractor from contracting with, or submitting an offer, proposal, or bid to contract with the State of Tennessee to supply goods or services for a period of one year after a contractor is discovered to have knowingly used the services of illegal immigrants during the performance of this contract.
- e. For purposes of this Contract, "illegal immigrant" shall be defined as any person who is not either a United States citizen, a Lawful Permanent Resident, or a person whose physical presence in the United States is authorized or allowed by the federal Department of Homeland Security and who, under federal immigration laws and/or regulations, is authorized to be employed in the U.S. or is otherwise authorized to provide services under the Contract.

14. Group 5 in Section 4-1.1.a shall be amended by adding additional language to the end of the existing language.

Group 5: Enrollees that have not responded to TennCare's attempts to contact and/or enrollees that are in specified Groups/Populations defined and identified by the State and agreed to by both parties; and

15. Section 5-4 shall be amended by adding a new Section 5-4.e which shall read as follows:

- e. The administrative fee payments specified in Section 5-1 and the premium tax payments specified in 5-3.f of this Contract as amended, shall represent payment in full. TennCare shall not reimburse CONTRACTOR for any costs, liquidated damages and/or penalties incurred by the CONTRACTOR and which result from actions or inactions, including penalties associated with CONTRACTOR's failure to timely pay any and all expenses, fees, taxes and other regulatory/ministerial costs associated with the requirements of operating as an HMO in this state. The taxes, fees, expenses, and other regulatory/ministerial costs referenced herein shall include but not be limited to premium taxes associated with any and all obligations required by the Tennessee Health Maintenance Organization Act of 1986 codified at Tennessee Code Annotated § 56-32-201 et seq. or any subsequent amendments thereto and/or the Tennessee Prepaid Limited Health Services Act of 2000 codified at Tennessee Code Annotated § 56-51-101 et seq. or any subsequent amendments thereto.

16. Section 6-1 shall be amended by adding a new Section 6-1.ee which shall read as follows:

- ee. Federal Pro-Children Act of 1994 and the Tennessee Children's Act for Clean Indoor Air of 1995.

17. Section 6-7 shall be deleted and replaced in its entirety so that the amended Section 6-7 shall read as follows:

6-7. CONFLICT OF INTEREST

6-7.a. The CONTRACTOR warrants that no part of the total Agreement amount provided herein shall be paid directly, indirectly or through a parent organization, subsidiary or an affiliate organization to any state or federal officer or employee of the State of Tennessee or any immediate family member of a state or federal officer or employee of the State of Tennessee as wages, compensation, or gifts in exchange for acting as officer, agent, employee, subcontractor, or consultant to the CONTRACTOR in connection with any work contemplated or performed relative to this Agreement unless disclosed to the Commissioner, Tennessee Department of Finance and Administration. For purposes of Section 6.7 and its subparts of this contract, "immediate family member" shall mean a spouse or minor child(ren) living in the household.

6-7.a.1 Quarterly, by January 30, April 30, July 30, and October 30 each year, or at other times or intervals as designated by the Deputy Commissioner of the Bureau of TennCare, disclosure shall be made by the CONTRACTOR to the Deputy Commissioner of the Bureau of TennCare, Department of Finance and Administration in writing. The disclosure shall include, but not be limited to, the following:

6-7.a.1.(a) A list of any state or federal officer or employee of the State of Tennessee as well as any immediate family member of a state or federal officer or employee of the State of Tennessee who receives wages or compensation from the CONTRACTOR; and

6-7.a.1.(b) A statement of the reason or purpose for the wages or compensation. The disclosures shall be made by the CONTRACTOR and reviewed by TENNCARE in accordance with Standard Operating Procedures and the disclosures shall be distributed to, amongst other persons, entities and organizations, the Commissioner, Tennessee Department of Finance and Administration, the Tennessee Ethics Commission, the TennCare Oversight Committee and the Fiscal Review Committee.

6-7.a.2 This Agreement may be terminated by TENNCARE and/or the CONTRACTOR may be subject to sanctions, including liquidated damages, under this Agreement if it is determined that the CONTRACTOR, its agents or employees offered or gave gratuities of any kind to any state or federal officials or employees of the State of Tennessee or any immediate family member of a state or federal officer or employee of the State of Tennessee if the offering or giving of said gratuity is in contravention or violation of state or federal law. It is understood by and between the parties that the failure to disclose information as required under Section 6.7 of this Agreement may result in termination of this Agreement and the CONTRACTOR may be subject to sanctions, including liquidated damages in accordance with Section 6-8 of this Agreement. The CONTRACTOR certifies that no member of or delegate of Congress, the United States General Accounting Office, DHHS, CMS, or any other federal agency has or will benefit financially or materially from this Agreement.

6-7.b The CONTRACTOR shall include language in all subcontracts and provider agreements and any and all agreements that result from this Agreement between CONTRACTOR and TENNCARE to ensure that it is maintaining adequate internal controls to detect and prevent conflicts of interest

from occurring at all levels of the organization. Said language may make applicable the provisions of Section 6-7 to all subcontracts, provider agreements and all agreements that result from the Agreement between the CONTRACTOR and TENNCARE.

18. Section 6-8.b.1 shall be amended by adding a due date for Semi-Annual Reports which shall read as follows:

Semi-Annual Reports	January 31 and July 31.
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19. Section 6-27 shall be amended by deleting and replacing December 31, 2006 with December 31, 2007.

6-27 Contract Term of The Agreement

This Agreement and its incorporated attachments, if any, as well as all Amendments to this Agreement, contain all of the terms and conditions agreed upon by the parties, and when executed by all parties, supersedes any prior agreements. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall be in effect from July 1, 2001, subject to approval by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The term of this Agreement shall expire on December 31, 2007. At the mutual agreement of TennCare and the CONTRACTOR, this CONTRACT shall be renewable for an additional twelve month period.

Notwithstanding any provision herein to the contrary, the State may terminate this Agreement if the waiver governing TennCare is terminated. The documents referenced in the Agreement are on file with the CONTRACTOR and with TENNCARE and the CONTRACTOR is aware of their content. No other agreement, oral or otherwise regarding the subject matter of this Agreement, shall be deemed to exist or to bind any of the parties hereto.

20. Attachment II shall be deleted and replaced in its entirety and shall read as follows:

ATTACHMENT II

ATTESTATION RE PERSONNEL USED IN CONTRACT PERFORMANCE

SUBJECT CONTRACT NUMBER:	
CONTRACTOR LEGAL ENTITY NAME:	
FEDERAL EMPLOYER IDENTIFICATION NUMBER: (or Social Security Number)	

The Contractor, identified above, does hereby attest, certify, warrant, and assure that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract.

**SIGNATURE &
DATE:**

NOTICE: This attestation MUST be signed by an individual empowered to contractually bind the Contractor. If said individual is not the chief executive or president, this document shall attach evidence showing the individual's authority to contractually bind the Contractor.

21. Attachment XII, Exhibit L.3 shall be amended by adding MRI, CT Scan and PET Scan's per 1000.

All of the provisions of the original Contract not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective January 1, 2007 or as of the date it is approved by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

VOLUNTEER STATE HEALTH PLAN, INC.

BY: M.D. Goetz Jr / scp
M. D. Goetz, Jr.
Commissioner

BY: Ronald E. Harr
Ronald E. Harr
President and Chief Executive Officer

DATE: 12-21-06

DATE: Dec 20, 2006

APPROVED BY:

APPROVED BY:

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

**STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY**

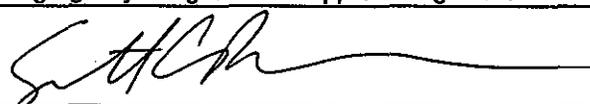
BY: M.D. Goetz Jr / scp
M. D. Goetz, Jr.
Commissioner

BY: John G. Morgan
John G. Morgan
Comptroller

DATE: 12/28/06

DATE: 1-3-07

CONTRACT SUMMARY SHEET

RFS Number: 318.66-026		Contract Number: FA-02-14632-15	
State Agency: Department of Finance and Administration		Division: Bureau of TennCare	
Contractor		Contract Identification Number	
VSHP (TennCare Select)		<input type="checkbox"/> V- <input type="checkbox"/> C-	
Service Description			
Managed Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medicaid Population			
Contract Begin Date		Contract End Date	
7/1/2001		12/31/2006	
Allotment Code	Cost Center	Object Code	Fund
318.66	4A2	134	11
		<input type="checkbox"/> STARS	
FY	State Funds	Federal Funds	Interdepartmental Funds
			Other Funding
			Total Contract Amount (including ALL amendments)
2002	\$ 6,755,937.23	\$ 11,843,931.25	\$ 18,599,868.48
2003	\$ 15,785,123.40	\$ 17,294,819.40	\$ 33,079,942.80
2004	\$ 25,125,990.72	\$ 38,364,165.90	\$ 63,490,156.62
2005	\$ 58,007,447.00	\$ 58,007,447.00	\$ 116,014,894.00
2006	\$ 87,748,111.00	\$ 87,748,111.00	\$ 175,496,222.00
2007	\$ 51,672,172.00	\$ 51,672,172.00	\$ 103,344,344.00
Total:	\$ 245,094,781.35	\$ 264,930,646.55	\$ 510,025,427.90
CFDA#	93.778 Title XIX Dept. of Health & Human Svcs.		Check the box ONLY if the answer is YES:
State Fiscal Contract			Is the Contractor a SUBRECIPIENT? (per OMB A-133)
Name:	Scott Pierce		Is the Contractor a Vendor? (per OMB A-133)
Address:	310 Great Circle Road		Is the Fiscal Year Funding STRICTLY LIMITED?
Phone:	Nashville, TN (615)507-6415		Is the Contractor on STARS?
Procuring Agency Budget Officer Approval Signature			Is the Contractor's FORM W-9 ATTACHED?
Scott Pierce 			Is the Contractor's Form W-9 Filed with Accounts?
COMPLETE FOR ALL AMENDMENTS (only)			Funding Certification
	Base Contract & Prior Amendments	This Amendment ONLY	Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.
CONTRACT END DATE:	12/31/2006		
FY: 2002	\$ 18,599,868.48		
FY: 2003	\$ 33,079,942.80		
FY: 2004	\$ 63,490,156.62		
FY: 2005	\$ 116,014,894.00		
FY: 2006	\$ 175,496,222.00		
FY: 2007	\$ 58,007,447.00	\$ 45,336,897.00	
Total:	\$ 464,688,530.90	\$ 45,336,897.00	

OCR RELEASED
 JUN 30 2006
TO ACCOUNTS

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 2006 JUN 27 AM 10:28
 COMPTROLLER'S OFFICE
 OFFICE OF
 MANAGEMENT SERVICES

OCR
 JUN 26 2006
 RECEIVED

CONTRACT SUMMARY SHEET

RFA Number: 318.88-026		Contract Number: FA-02-14832-15	
State Agency: Department of Finance and Administration		Division: Bureau of TennCare	
Contractor: V&HP (TennCare Select)		Contract Identification Number:	
		<input type="checkbox"/> V- <input type="checkbox"/> C-	
Service Description: Managed Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medicaid Population			
Contract Begin Date: 7/1/2001		Contract End Date: 12/31/2008	
Allocation Code: 318.88	Cost Center: 4A2	Object Code: 134	Fund: 11
			<input type="checkbox"/> STAR8
FY	State Funds	Federal Funds	Interdepartmental Funds
2002	\$ 6,756,937.23	\$ 11,543,931.25	
2003	\$ 15,785,123.40	\$ 17,284,819.40	
2004	\$ 25,125,980.72	\$ 38,364,165.90	
2005	\$ 58,007,447.00	\$ 58,007,447.00	
2006	\$87,748,111.00	\$87,748,111.00	
2007	\$51,672,172.00	\$51,672,172.00	
Total:	\$245,084,781.35	\$ 284,630,646.55	
CFDA#	93.778 Title XIX Dept. of Health & Human Svcs.		
State Fiscal Contract		Check the box ONLY if the answer is YES:	
Name: Scott Pierce	Address: 310 Great Circle Road		Is the Contractor a SUBRECIPIENT? (per OMB A-133)
Phone: (615)997-8416	Nashville, TN		Is the Contractor a Vendor? (per OMB A-133)
Procuring Agency Budget Officer Approval Signature		Is the Fiscal Year Funding STRICTLY LIMITED?	
Scott Pierce			Is the Contractor on STAR8?
COMPLETE FOR ALL AMENDMENTS (only)		Is the Contractor's FORM W-9 ATTACHED?	
Funding Certification		Is the Contractor's Form W-9 Filed with Accounts?	
Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred			
CONTRACT END DATE:	Base Contract & Prior Amendments	This Amendment ONLY	
FY: 2002	\$ 18,599,888.48		
FY: 2003	\$ 33,078,942.80		
FY: 2004	\$ 63,480,166.62		
FY: 2005	\$116,014,884.00		
FY: 2006	\$175,488,222.00		
FY: 2007	\$58,007,447.00	\$45,338,897.00	
Total:	\$454,668,530.90	\$45,338,897.00	

M. D. Goetz, Jr.

1/31

AMENDMENT NUMBER 15

**AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.**

CONTRACT NUMBER: FA-02-14632-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Amended and Restated Contractor Risk Agreement (CRA) by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and VOLUNTEER STATE HEALTH PLAN, INC., hereinafter referred to as the CONTRACTOR as specified below.

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. For clarification purposes to describe current TENNCARE policy, Section 1-3 shall be amended by adding the phrase "with the exception of Medical Case Management" and correcting references to the definition of Administrative Cost and adding a new definition of Medical Expenses which shall read as follows:

Administrative Cost - All costs to the Contractor related to the administration of this Agreement that are non-medical in nature, including, but not limited to:

- Satisfying Contractor Qualifications specified in Sections 2-1 and 2-2;
- Establishing and Maintaining a Provider Network in accordance with the Access and Availability requirements specified in Section 2-4.1, Attachment III and Attachment IV;
- Determination of recoveries from Third Party Liability resources in accordance with Section 2-9.8;
- Claims Processing in accordance with Section 2-9.7;
- Administration of this Agreement in accordance with Medical Management Policies and Procedures including: Utilization Management policies and procedures, including prior authorization policies and procedures established in accordance with Section 2-7.1; Referral and Exemption Requirements established in accordance with Section 2-4.4; Out of Area or Out of Plan Use policies and procedures established in accordance with Section 2-4.7; Transplant policies and procedures established in accordance with Section 2-3.13; Prescription Drug Formulary established in accordance with Section 2-3.14; Prenatal Care policies and procedures established in accordance with Section 2-7.1.f.3 and 2-3.16; Quality Monitoring/Quality Improvement Program established in accordance with Section 2-9.6; Management of Medical Care and Coordination of Care policies and procedures established in accordance with Sections 2-4.2 and 2-4.3 with the exception of Medical Case Management;
- Enrollment and Disenrollment in accordance with Section 4;
- Appeals processing and resolution in accordance with Section 2-8;
- Quality Assurance and Improvement activities as specified in Section 2-9.6 and Attachment II;
- Production and submission of required reports as specified in Section 2-10;
- Production and distribution of Marketing and Enrollee Materials as specified in Section 2-6;
- All other Administration and Management responsibilities as specified in Sections 2-11 through 2-24 and other activities required to be conducted in Attachment I, V, VI, VII, XI, XII, XIII; and

Amendment Number 15 (cont.)

- All costs related to third party recovery or subrogation activities whether performed by the Contractor or a subcontractor.

Costs of subcontractors engaged solely to perform a non-medical administrative function for the CONTRACTOR specifically related to securing or fulfilling the CONTRACTOR's obligations to TENNCARE under the terms of this Agreement (e.g., claims processing, marketing) are considered to be an "administrative cost" with the exception of the cost of recovery of third party liability (TPL), when approved by TENNCARE.

Medical Expenses (sometimes referred to as "Covered Services") - Consist of the following:

- a. The cost of providing TennCare Program medical services to enrollees as identified below and pursuant to the following listed subsections of Section 2-3 of the CRA:
 1. 2-3.1 Covered Benefits
 2. Coordination, 2-3.5 and 6 Dental Services/Mental Health and Substance Abuse Services
 3. 2-3.10 Use of Cost Effective Alternative Services
 4. 2-3.11 Coverage of Sterilization's, Abortions and Hysterectomies pursuant to applicable federal and state laws and regulations
 5. 2-3.13 Coverage of Organ and Tissue Transplants
 6. all services related to hospice
 7. capitated payment to licensed health care providers
 8. medical services directed by TENNCARE or an Administrative Law Judge
 9. net impact of reinsurance coverage purchased by the MCO
- b. Preventive Services: In order for preventive services in Section 2-3 (including, but not limited to, health education, medical case management and health promotion activities) to qualify as medical expenses, the service must be targeted to and limited to the CONTRACTOR's enrollees or targeted to meet the enrollee's individual needs and the allocation methodology for capturing said costs must be approved by TENNCARE.
- c. Medical case management may qualify as medical expenses if the service is targeted to meet the enrollee's individual needs and the allocation methodology for capturing said costs is approved by TENNCARE.
- d. Medical Expenses do not include:
 1. 2-5. Services Not Covered;
 2. 2-3.8. Institutional Services and Alternatives to Institutional Services;
 3. Services eligible for reimbursement by Medicare;
 4. The activities described in or required to be conducted in Attachments I, II, III, IV, V, VI, VII, XI, XII, XIII (including, but not limited to, utilization management, utilization review activities) are administrative costs; and
 5. The two percent HMO tax.
- e. Medical expense will be net of any TPL recoveries or subrogation activities. If approved by TENNCARE, the TPL or subrogation recoveries may be net of administrative expenses incurred that are related to recovery activities.
- f. Medical expense will be net of any pharmacy rebates.

Amendment Number 15 (cont.)

f. This definition does not apply to NAIC filings.

2. Section 1-3 shall be amended by deleting and replacing the definition of “Medically Necessary” so that the amended definition shall read as follows:

Medically Necessary – Shall be defined by Tennessee Code Annotated, Section 71-5-144, and shall describe a medical item or service that meets the criteria set forth in that statute. The term “medically necessary,” as defined by Tennessee Code Annotated, Section 71-5-144, applies to TennCare enrollees. Implementation of the term “medically necessary” is provided for in regulations at 1200-13-16-.01, consistent with the statutory provisions, which control in case of ambiguity. No enrollee shall be entitled to receive and TennCare shall not be required to pay for any items or services that fail fully to satisfy all criteria of “medically necessary” items or services, as defined either in the statute or in regulations at 1200-13-16-.01.

3. Section 2-3.1.2 shall be deleted and replaced in its entirety so that the amended Section 2-3.1.2 shall read as follows:

2-3.1.2 TennCare Benefits, effective July 1, 2006:

Should TENNCARE eliminate a specified population from eligibility in the TennCare Program, Services/Benefits listed below shall no longer be applicable for said population.

<u>SERVICE</u>	<u>BENEFIT</u>
Inpatient Hospital Services	<p>Medicaid/Standard Eligible, Age 21 and older: As medically necessary. Inpatient rehabilitation hospital facility services are Not covered for adults. May be provided by the CONTRACTOR if determined by the CONTRACTOR to be a cost effective alternative.</p> <p>Medicaid/Standard Eligible, Under age 21: As medically necessary, rehabilitation hospital facility services are covered under EPSDT for Medicaid eligible children and as medically necessary for Standard eligible children.</p>
Outpatient Hospital Services	As medically necessary.
Physician Inpatient Services	As medically necessary.
Physician Outpatient Services/Community Health Clinic Services/Other Clinic Services	<p>As medically necessary.</p> <p>NOTE: CONTRACTOR covered services shall include the following:</p> <ul style="list-style-type: none"> • Services provided by a Primary Care Provider with a primary behavioral health diagnosis (ICD-9-CM 290.xx - 319.xx). • Behavioral health services described in CPT procedure code range 96150 through 96155. • Medical evaluations provided by a neurologist, as approved by the CONTRACTOR, and/or an emergency room provider, that result in a primary behavioral health diagnosis (ICD-9-CM 290.xx - 319.xx).

<p>EPSDT Services for enrollees under age 21 in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.</p>	<p>Medicaid/Standard Eligibles, Age 21 and older: not covered.</p> <p>Medicaid/Standard Eligibles, Under age 21: Covered as medically necessary, except that the screenings do not have to be medically necessary. Children may also receive screenings in-between regular checkups if a parent or caregiver believes there is a problem.</p> <p>Screening, interperiodic screening, diagnostic and follow-up treatment services as medically necessary in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989 for enrollees under 21. Except for Dental services, Screens shall be in accordance with the periodicity schedule set forth in the latest "American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care" and all components of the screens must be consistent with the latest "American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care". Dental screens shall be in accordance with the latest periodicity schedule set forth by the American Academy of Pediatric Dentistry and all components of the screens must be consistent with the latest recommendations by the American Academy of Pediatric Dentistry. Tools to be used for screenings shall be consistent with the EPSDT Screening Guidelines as described in Attachment VIII of the Contract. EPSDT services also include maintenance services which are services which have been determined to be effective in preventing or mitigating the worsening of an individual's conditions or preventing the development of additional health problems.</p>
<p>Preventive Care Services</p>	<p>As described in Section 2-3.3.</p>
<p>Lab and X-ray Services</p>	<p>As medically necessary.</p>
<p>Hospice Care</p>	<p>As medically necessary. Must be provided by a Medicare-certified hospice.</p> <p>If a Medicaid hospice patient resides in a nursing facility (NF), the CONTRACTOR must pay an amount equal to at least 95 percent of the prevailing NF room and board rate to the hospice provider.</p>
<p>Dental Services</p>	<p>Dental Services shall be provided by the Dental Benefits Manager.</p> <p>Medicaid/Standard Eligible, Age 21 and older: Non-covered.</p> <p>Medicaid/Standard Eligible, Under age 21: The CONTRACTOR shall cover Dental preventive, diagnostic and treatment services for enrollees under age 21. Orthodontics limited to individuals under 21 except when an orthodontic treatment plan is approved prior to the enrollee attaining 20 1/2 years of age, and treatment is initiated prior to the recipient attaining 21 years of age.</p>

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	<p>Effective October 1, 2002, the aforementioned covered dental services shall be provided by the Dental Benefits Manager. The provision of transportation to and from said services as well as the medical and anesthesia services related to the dental service that are not provided by a dentist or in a dentist's office shall remain with the CONTRACTOR when the dental service is covered by the DBM.</p> <p>(See Section 2-3.1, and 2-3.5)</p>
<p>Vision Services</p>	<p>Medicaid/Standard Eligible, Age 21 and older: Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of refractive state), will be covered but shall be subject to the service limitations as described elsewhere in this Contract. Routine periodic assessment, evaluation, or screening of normal eyes and examinations for the purpose of prescribing fitting or changing eyeglass and/or contact lenses will not be covered. One pair of cataract glasses or lenses is covered for adults following cataract surgery.</p> <p>Medicaid/Standard Eligible, Under age 21: Preventive, diagnostic, and treatments services (including eyeglasses), are covered as medically necessary.</p>
<p>Home Health Care</p>	<p>As medically necessary.</p>
<p>Pharmacy Services</p>	<p>Pharmacy services shall be provided by the Pharmacy Benefits Manager (PBM), unless otherwise described below.</p> <p>Non-Institutionalized Mandatory and Optional (other than Medically Needy) Medicaid Adults (Age 21 and older) and Medically Needy Adults (Age 21 and older): 5 Prescriptions per Month of which only 2 may be Brand name</p> <p>Institutionalized Medicaid Adults (Age 21 and older): As medically necessary</p> <p>Standard Eligible, Age 21 and older: Non-covered</p> <p>Medicaid/Standard Eligible, Under age 21: As medically necessary</p> <p>NOTE: Certain drugs (known as DESI, LTE, or IRS drugs) are excluded from coverage.</p> <p>Limits on Pharmacy benefits as well as the effective dates thereof are subject to change based on Waiver and/or Court negotiations.</p> <p>Effective July 1, 2003, the aforementioned covered pharmacy</p>

	<p>services shall be provided by the Pharmacy Benefits Manager (PBM) contracted by the TENNCARE Bureau. Pharmacies providing home infusion drugs and biologics only (not including services) shall bill the PBM.</p> <p>Diabetic monitors and supplies as well as injectable drugs obtained directly from a pharmacy provider shall be included in the covered pharmacy services that will be provided by the TennCare Pharmacy Benefit Manager effective July 1, 2003.</p> <p>CONTRACTOR RESPONSIBILITIES: The CONTRACTOR shall be responsible for reimbursement of injectable drugs obtained in an office/clinic setting in accordance with benefits described herein and to providers providing both home infusion services and the drugs and biologics. Effective July 1, 2005, the CONTRACTOR shall require that all home infusion claims contain NDC coding and unit information to be paid.</p> <p>Services reimbursed by the CONTRACTOR shall not be included in the Pharmacy Benefit Limits as described above.</p> <p>Effective January 1, 2006, provision and payment of pharmacy benefits to individuals who are enrolled in the TennCare Program in the category of TennCare Medicaid/Medicare dual eligible shall be administered by Medicare Part D.</p>
<p>Durable Medical Equipment</p>	<p>As medically necessary.</p> <p>Specified DME services shall be covered/non-covered in accordance with the TennCare rules and regulations.</p>
<p>Medical Supplies</p>	<p>As medically necessary.</p> <p>Specified Medical Supplies shall be covered/non-covered in accordance with the TennCare rules and regulations.</p>
<p>Emergency Air And Ground Ambulance Transportation</p>	<p>As medically necessary.</p>
<p>Non-emergency Transportation (including Non-Emergency Ambulance Transportation)</p>	<p>As necessary to get an enrollee to and from covered services, for enrollees not having access to transportation. MCOs may require advance notice of the need in order to timely arrange transportation.</p> <p>The travel to access primary care and dental services must meet the requirements of the waiver terms and conditions. The availability of specialty services as related to travel distance should meet the usual and customary standards for the community. However, in the event the MCO is unable to negotiate such an arrangement for an enrollee, transportation must be provided regardless of whether or not the enrollee has access to transportation. If the enrollee is a child, transportation must be provided for the child and an accompanying</p>

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	<p>adult. However, transportation for a child shall not be denied pursuant to any policy which poses a blanket restriction due to enrollees age or lack of parental accompaniment. Any decision to deny transportation of a child due to an enrollees age or lack of parental accompaniment must be made on a case-by-case basis and must be based on the individual facts surrounding the request. As with any denial, all notices and actions must be in accordance with the appeal process.</p> <p>The CONTRACTOR shall provide transportation to and from Dental Services.</p>
Renal Dialysis Services	As medically necessary.
Private Duty Nursing	As medically necessary and when prescribed by an attending physician for treatment and services rendered by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), who is not an immediate relative.
Speech Therapy	<p>Medicaid/Standard Eligible, Age 21 and older: Covered as medically necessary by a Licensed Speech Therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic or personality disorder.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with EPSDT requirements.</p>
Occupational Therapy	<p>Medicaid/Standard Eligible, Age 21 and older: Covered as medically necessary when provided by a Licensed Occupational Therapist to restore, improve, or stabilize impaired functions.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with EPSDT requirements.</p>
Physical Therapy	<p>Medicaid/Standard Eligible, Age 21 and older: Covered as medically necessary when provided by a Licensed Physical Therapist to restore, improve, or stabilize impaired functions.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with EPSDT requirements.</p>
Organ and Tissue Transplant And Donor Organ Procurement	<p>Medicaid/Standard Eligible, Age 21 and older: All medically necessary and non-investigational/experimental organ and tissue transplants, as covered by Medicare, are covered. These include, but may not be limited to:</p> <ul style="list-style-type: none"> Bone marrow/Stem cell; Cornea; Heart; Heart/Lung;

	<p>Kidney; Kidney/Pancreas; Liver; Lung; Pancreas; and Small bowel/Multi-visceral.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with EPSDT requirements. Experimental or investigational transplants are not covered.</p>
Reconstructive Breast Surgery	<p>Covered in accordance with TCA 56-7-2507, which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy, as well as surgical procedures on the non-diseased breast to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast to establish symmetry with the diseased breast will only be covered if the surgical procedure performed on a non-diseased breast occurs within five (5) years of the date the reconstructive breast surgery was performed on a diseased breast.</p>
Chiropractic Services	<p>Medicaid/Standard Eligible, Age 21 and older: Not covered. May be provided by the CONTRACTOR if determined by the CONTRACTOR to be a cost effective alternative.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with EPSDT requirements.</p>
Sitter	<p>Medicaid/Standard Eligible, Age 21 and older: NON COVERED.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary.</p>
Convalescent Care	<p>Medicaid/Standard Eligible, Age 21 and older: NON COVERED</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary.</p>

4. Section 2-3 shall be amended by adding a new Section 2-3.2 and renumbering the existing Sections accordingly and shall update all references thereto. The new Section 2-3.2 shall read as follows:

2-3.2. Soft Limits/Service Thresholds for Certain Physical Health Services

TENNCARE has established thresholds that apply to certain covered physical health services for non-institutionalized Medicaid adults. The CONTRACTOR shall track, in a manner prescribed by TENNCARE, and report on accumulated benefit information for each service that has a threshold. Depending on the service, once a member reaches a threshold, the CONTRACTOR shall evaluate and enroll the member in MCO case management or a disease management program as appropriate.

“Institutionalized Medicaid” are not subject to service thresholds and shall be defined as individuals who are receiving (as described in TennCare/Medicaid rules and regulations) long term care institutional services in a nursing home, an Intermediate Care Facility for the Mentally

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Retarded (ICF/MR) or waiver covered services provided through the Home and Community Based Services (HCBS) waiver for these institutional services.

2-3.2(a) The service thresholds and the CONTRACTOR's responsibility once a non-institutionalized adult has met the threshold are as follows:

Service	Threshold for Non-Institutionalized Medicaid Eligibles, Age 21 and Older	CONTRACTOR Responsibility Once Member Has Reached Threshold
Inpatient Hospital Services	20 days per SFY	Enroll member in MCO case management or disease management program, whichever is more appropriate
Outpatient Hospital Services	8 visits per SFY	Determine whether member should be enrolled in MCO case management or a disease management program and enroll member if appropriate
Physician Outpatient Services/Community Health Clinic Services/Other Clinic Services	12 visits per SFY	Determine whether member should be enrolled in MCO case management or a disease management program and enroll member if appropriate
Lab and X-ray Services	10 visits per SFY	Determine whether member should be enrolled in MCO case management or a disease management program and enroll member if appropriate

2-3.2(b) The CONTRACTOR shall report, on a quarterly basis as described in Section 2-10.18, the number of members who reach each threshold, were assessed, and/or were enrolled in MCO case management or a disease management program, and the reasons for failure to enroll in MCO case management or disease management.

5. The second paragraph of the renumbered Section 2-3.17 shall be amended by adding a new third sentence so that the first two paragraphs of Section 2-3.17 shall read as follows:

2-3.17. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Requirements

The CONTRACTOR must have written policies and procedures for an EPSDT program that includes coordinating services with other TennCare providers, providing all medically necessary Title XIX EPSDT services to all eligible individuals under the age of twenty-one (21) regardless of whether the service is included in the Medicaid State Plan, as well as outreach and education. The CONTRACTOR must assure the availability and accessibility of required health care resources and help enrollees and their parents or guardians use these resources effectively. The State EPSDT program shall be referred to as "TENnderCare". The CONTRACTOR shall use "TENnderCare" in describing or naming an EPSDT program or services. This shall include, but not be limited to, all policies, procedures and/or marketing material, regardless of the format or

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media. No other names or labels shall be utilized. CONTRACTORS may, however, use existing EPSDT materials through December 31, 2004. Any new or reprinted EPSDT materials shall use TENNderCare as of July 1, 2004.

The CONTRACTOR shall provide EPSDT services to enrollees under age 21 in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989. EPSDT Services means early and periodic screening, diagnosis and treatment of enrollees under age 21 made pursuant to 42 U.S.C. Sections 1396a(a)(43), 1396d(a) and (r) and 42 CFR Part 441, Subpart B to ascertain children's individual (or individualized/or on an individual basis) physical and mental defects, and providing treatment to correct or ameliorate, or prevent from worsening defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the state plan. The CONTRACTOR shall be responsible for and comply with all provisions related to screening, vision, dental, and hearing services (including making arrangements for necessary follow-up if all components of a screen cannot be completed in a single visit). The CONTRACTOR shall be responsible for the provision of all related services except for behavioral health services that are carved out as a separate arrangement from this Contract as well as Pharmacy and Dental services at such time as they are removed from the responsibilities described in this Contract. Effective upon receipt of written notification from TENNCARE, the CONTRACTOR is not required to provide services in accordance with EPSDT requirements to TennCare Standard enrollees under the age of 21.

6. The renumbered Section 2-3.17.2 shall be amended by deleting and replacing the last paragraph so that the amended Section 2-3.17.2 shall read as follows:

2-3.17.2 42 CFR 441.56(b) defines "screening" as "periodic comprehensive child health assessments" meaning "regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth." At a minimum, screenings must include, but are not limited to:

1. Comprehensive health and developmental history;
2. Comprehensive unclothed physical examination;
3. Appropriate Immunizations;
4. Appropriate vision and hearing testing;
5. Appropriate laboratory tests; and
6. Dental screening services furnished by direct referral to a dentist for children no later than 3 years of age and should be referred earlier as needed (as early as 6 to 12 months in accordance with the American Academy of Pediatric Dentistry (AAPD) guidelines) and as otherwise appropriate; and
7. Health Education.

At a minimum, these screening services shall include periodic and interperiodic screens and must be provided in accordance with "reasonable standards of medical and dental practice" as determined by the State. The State has determined that "reasonable standards of medical and dental practice" are those standards set forth in the American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care for medical practice and American Academy of Pediatric Dentistry (AAPD) guidelines for dental practice. Pursuant to Section 2-3.4, "screens shall be in accordance with the periodicity schedule set forth in the latest 'American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care' and all components of the screens must be consistent with the latest 'American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care' and the American Academy of Pediatric Dentistry (AAPD) guidelines. The CONTRACTOR shall not require prior authorization for periodic and interperiodic screens conducted by PCPs. The CONTRACTOR shall provide all

medically necessary TENNderCare covered services regardless of whether or not the need for such services was identified by a provider whose services had received prior authorization from the CONTRACTOR or by an in-network provider.

7. Section 2-4.6 shall be amended by adding new language to the end of the existing text so that the amended Section 2-4.6 shall read as follows:

2-4.6 Network Notice Requirements

All member notices required shall be written using the appropriate notice templates provided by TENNCARE and shall include all notice content requirements specified in applicable state and federal law, TennCare rules and regulations, and all court orders and consent decrees governing notice and appeal procedures, as they become effective. The CONTRACTOR shall provide notice of changes to its provider network as specified below.

Failure to comply with notice requirements described herein may result in liquidated damages as described in Section 6-8.b.2 of this Agreement.

8. Section 2-4.6.2.c shall be amended by deleting and replacing the first sentence of the first paragraph so that the amended Section 2-4.6.2.c shall read as follows:

c. Other Provider Terminations

Other Provider Terminations. The CONTRACTOR shall notify TennCare of any provider termination and submit a copy of one of the actual member notices mailed as well as an electronic listing identifying each member to whom a notice was sent within five (5) business days of the date the member notice was sent as required in Section 2-4.6.1. In addition to the member notice and electronic listing, documentation from the CONTRACTOR's mail room or outside vendor indicating the quantity and date member notices were mailed shall be sent to TENNCARE as proof of compliance with the member notification requirements. The CONTRACTOR shall maintain a copy of the actual notice on-site and forward a copy of the notices upon request from TENNCARE. If the termination was initiated by the provider, said notice shall include a copy of the provider's notification to the Contractor.

Furthermore, if termination of the CONTRACTOR's provider agreement with any primary care provider or physician group or clinic, whether or not the termination is initiated by the provider or by the CONTRACTOR, places the CONTRACTOR out of compliance with Section 2-4, such termination shall be reported by the CONTRACTOR in writing to the Bureau of TennCare, in the standard format used to demonstrate compliance with provider network and access requirements, within five (5) business days of the date that the agreement has been terminated.

9. The second paragraph of Section 2-4.7.1 shall be amended by deleting the phrase "and subsequent steps regarding an informal review by TENNCARE" so that the amended Section 2-4.7.1 shall read as follows:

2.4.7.1 Emergency Medical Services obtained from Out of Plan Providers

The CONTRACTOR's plan shall include provisions governing utilization of and payment by the CONTRACTOR for emergency medical services received by an enrollee from non-contract providers, regardless of whether such emergency services are rendered within or outside the community service area covered by the plan. Coverage of emergency medical services shall not be subject to prior authorization by the CONTRACTOR and shall be consistent with federal requirements regarding post-stabilization services, including but not limited to, 42 CFR Section

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438.114(c)(1)(ii)(A). Utilization of and payments to non-contract providers may, at the CONTRACTOR's option, be limited to the treatment of emergency medical conditions, including post-stabilization care that includes medically necessary services rendered to the enrollee until such time as he/she can be safely transported to an appropriate contract service location. Payment amounts shall be consistent with the pricing policies developed by the CONTRACTOR and in accordance with TENNCARE requirements, including TENNCARE rules and regulations for emergency out-of-plan services. Payment by the CONTRACTOR for properly documented claims for emergency medical services rendered by a non-contract provider shall be made within thirty (30) calendar days of receipt of a clean claim by the CONTRACTOR.

The CONTRACTOR must review and approve or disapprove claims for emergency medical services based on the definition of emergency medical services specified in Section 1-3 of this Contract. If the CONTRACTOR determines that a claim requesting payment of emergency medical services does not meet the definition as specified in Section 1-3 and subsequently denies the claim, the CONTRACTOR shall notify the provider of the denial. This notification shall include information to the provider regarding the CONTRACTOR's process and timeframes for reconsideration. In the event a provider disagrees with the CONTRACTOR's decision to disapprove a claim for emergency medical services, the provider may pursue the independent review process for disputed claims as provided by T.C.A., Section 56-32-226, including but not limited to MCO reconsideration.

10. Section 2-4.7.6 shall be amended by adding a new paragraph to the end of the existing text so that the amended Section 2-4.7.6 shall read as follows:

2-4.7.6. Credentialing of Non-Contract Providers

Credentialing Standards must apply to all licensed independent practitioners or groups of practitioners who have an independent relationship with the CONTRACTOR. An independent relationship is not synonymous with an independent contract.

The CONTRACTOR shall completely process credentialing applications within thirty (30) calendar days of receipt of a completed, including all necessary documentation and attachments, credentialing application. Completely process shall mean that the CONTRACTOR shall review, approve and load approved applicants to their provider files in their claims processing system or deny the application and assure that provider is not included in the CONTRACTOR's network.

11. Section 2-6.2.c.1 shall be amended by deleting and replacing Item (t) so that the amended Section 2-6.2.c.1(t) shall read as follows:

- (t) Shall include member services toll free telephone numbers; including the TENNCARE Hotline, the CONTRACTOR's customer service line and the CONTRACTOR's 24/7 Nurse Triage Line with a statement that the enrollee may contact the plan or TENNCARE regarding questions about TennCare as well as the service/information that may be obtained from each line. The TennCare hotline number is 1-866-311-4287;

12. Section 2-6.2.c.2 shall be amended by adding a new Item (e) and renumbering the existing item (e) as (f) so that the new Section 2-6.c.2.c.2(e) shall read as follows:

- (e) member services toll free telephone numbers; including the TennCare Hotline, the CONTRACTOR's customer service line and the CONTRACTOR's 24/7 Nurse Triage Line as well as the service/information that may be obtained from each line; and

13. Section 2-6.2.c.4 shall be amended by adding the phrase “or prior to enrollee’s beginning effective date” to the end of the first sentence so that the amended Section 2-6.2.c.4 shall read as follows:

4. Provider Directory

The CONTRACTOR shall be responsible for distributing provider directories to new members within thirty (30) calendar days of receipt of notification of enrollment in the plan or prior to enrollee’s beginning effective date. The CONTRACTOR shall also be responsible for redistribution of updated provider information on a regular basis and shall redistribute a complete and updated provider directory at least on an annual basis. Provider directories shall include the following: names, locations, telephone numbers, office hours, non-English languages spoken by current network PCPs and specialists, hospital listings including locations of emergency settings and post stabilization services, identification of providers accepting new patients and whether or not a provider performs EPSDT screens. Enrollee provider directories, and any revisions thereto, shall be submitted to TENNCARE for approval prior to distribution to enrollees. Each submission shall include a paper and an electronic copy. The text of the directory shall be in Microsoft Word or Adobe (PDF) format. In addition, the provider information used to populate the enrollee provider directory shall be submitted as a TXT file or such format as otherwise approved by TENNCARE and be produced using the same extract process as the actual enrollee provider directory. In situations where there is more than one enrollee in a TennCare case, it shall be acceptable for the CONTRACTOR to mail one (1) provider directory to each address listed for the enrollee’s TennCare case number when there is more than one (1) new enrollee assigned to the same case number at the time of enrollment and when subsequent updated provider directories are mailed to enrollees. Should a single individual be enrolled and be added into an existing case, a provider directory must be mailed to that individual regardless of whether or not a provider directory has been previously mailed to enrollees in the existing case. These updates shall be maintained in accordance with Section 2-1.o of this Contract.

14. Section 2-7.1.b shall be deleted and replaced in its entirety so that the amended Section 2-7.1.b shall read as follows:

b. MCO Case Management

- (1) The CONTRACTOR shall maintain an MCO case management program that includes the following components:
- (a) A systematic approach to identify eligible members;
 - (b) Assessment of member needs;
 - (c) Development of an individualized plan of care;
 - (d) Implementation of the plan of care, including coordination of care that actively links the member to providers and support services; and
 - (e) Monitoring of outcomes.
- (2) The CONTRACTOR shall provide MCO case management to members who are at high risk or have unique, chronic, or complex needs. This shall include but not be limited to:
- (a) Members who have reached the service threshold for inpatient hospital services;
 - (b) Members who have reached the service threshold for non-inpatient hospital services and could potentially benefit from enrollment in MCO case management;
 - (c) Members with co-occurring mental illness and substance abuse, and/or co-morbid physical health and behavioral health conditions;

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- (d) Members who meet the requirements at 2-7.1.b(1) regarding excessive and/or inappropriate Emergency Department Utilization. and
 - (e) Children with special health care needs unless already enrolled in an appropriate disease management program.
- (3) Members who have reached the service threshold for inpatient hospital services shall be enrolled in either MCO case management or a disease management program.
 - (4) Eligible members must be offered MCO case management services. However, member participation shall be voluntary.
 - (5) The CONTRACTOR shall develop a process to inform members and providers about the availability of MCO case management and to inform the member's PCP when a member has been assigned to the MCO case management program.
 - (6) The CONTRACTOR shall use utilization data, including pharmacy data provided by TENNCARE or its PBM to identify members for MCO case management services as appropriate. In particular, the CONTRACTOR shall track utilization data to determine when a member has reached a service threshold.
15. Section 2-7.1.e shall be amended by adding additional text to the end of the existing text so that the amended Section 2-7.1.e shall read as follows:

e. Excessive and/or Inappropriate Emergency Department (ED) Utilization. The CONTRACTOR shall utilize the following guidelines in identifying and managing care for enrollees who are determined to have excessive and/or inappropriate ED utilization.

- (1) Review ED utilization data, at a minimum, every six (6) months (in January and July) to identify enrollees with utilization exceeding a threshold defined by TENNCARE in the preceding six (6) month period. In January, review ED utilization during the preceding April through September. In July review ED utilization during the preceding October through March.
- (2) Enroll in active case management -- (Enrollees who exceed a specified number, to be defined by TENNCARE, of ED visits in the previous six (6) month period)
- (3) Make contact with enrollee and primary care provider
- (4) Review encounter data
- (5) Assess most likely cause of problem (e.g., drug seeking behavior, primary care/access problem, poorly controlled disease state, etc.)
- (6) Develop a case management plan based on results of the assessment. Sample plans based on potential assessment results follow:
 - (a) Drug seeking behavior
 - i. Interact with TennCare Pharmacy Division regarding possibility of pharmacy lock-in and/or controlled substance prior authorization requirement
 - ii. Contact all providers regarding concern that patient may be abusing prescription medications
 - iii. Make appropriate referrals (e.g., OIG, Pain clinic, Substance abuse treatment program, etc.)
 - iv. Consider primary care provider lock-in (i.e. patient must have PCP approval before he/she can access other providers)
 - (b) Primary Care /Access Problem
 - i. Change PCP and/or address problem with current PCP

- ii. Provide enrollee education regarding appropriate use of PCP and ED
- iii. Provide access to a 1-800 customer service line for assistance identifying and selecting a PCP and to the extent necessary assistance scheduling an appointment with PCP
- (c) Poorly controlled disease
 - i. Enroll in disease management
 - ii. Refer to specialist for management – advise PCP
 - iii. Provide access to 1-800 24/7 nurse answered line capable of providing health information/education to patients; healthcare counseling/telephone triage to assess health status to steer patients to the appropriate level of care. The 24/7 Nurse Triage line shall assure effective patient management by avoiding over-utilization in inappropriate settings.
- (7) Any blanket policy to deny payment for specified "non-emergency" services in the ED based on diagnoses must be accompanied by the following guidelines.
 - (a) Clear communication to all hospitals/EDs regarding the diagnoses that are and are not considered emergencies;
 - (b) A process whereby the hospital could demonstrate that a condition on the list did, in fact, represent an emergency;
 - (c) Clear communication to all hospitals/EDs regarding the mechanism to bill for the EMTALA required screen associated with any non-emergency diagnoses;
 - (d) Payment for the EMTALA screens associated with any non-emergency diagnosis, and
 - (e) A specific process that the MCO shares with all hospitals/EDs by which the ED can contact the MCO 24/7 to refer an enrollee with one of the non-emergency diagnoses to the MCO for assistance in arranging for care in an alternative setting, when such assistance is requested by the member.
- (8) If the CONTRACTOR requires EDs to refer members with non-urgent/emergent conditions to alternative settings for treatment, the MCO must have a specific process in place whereby the ED can contact the MCO 24/7 to assist enrollees with non-urgent/emergent conditions who do not require inpatient admission and who are requesting assistance in scheduling an appointment in an alternate treatment setting.

If the CONTRACTOR chooses to implement a blanket policy as identified in subsection (g) above, failure to comply with the ED guidelines as described therein may result in liquidated damages as described in Section 4-8.b.2 of this Agreement.

16. Section 2-7.1.f shall be deleted in its entirety and replaced by a new Section 2-7.1.f which shall read as follows:

- f. Disease Management. Each MCO is required to establish and operate (either directly or via a subcontract with a disease management vendor) a minimum of four disease management (DM) programs designed to address maternity care management, comprehensive diabetes management, management of congestive heart failure and management of asthma.

Each DM program must utilize evidence-based best practice guidelines and patient empowerment strategies to support the practitioner-patient relationship and the plan of care. The programs must emphasize prevention of exacerbation and complications as evidenced by decreases in emergency room utilization and inpatient hospitalization and/or improvements in condition-specific health status indicators.

(1) DM Program Policies and Procedures

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The CONTRACTOR shall develop and maintain DM program policies and procedures. These policies and procedures must include, for each of the conditions listed above, the following:

- (a) Definition of the target population;
- (b) Member identification strategies;
- (c) Program content including, but not limited to:
 - (a) Evidence-based best practice guidelines upon which the program is based;
 - (b) Written description of the stratification levels for each of the conditions, including member criteria and associated interventions;
 - (c) Methods for informing and educating members;
 - (d) Methods for informing and educating providers; and
- (d) Program evaluation.

As part of its DM program policies and procedures, the CONTRACTOR shall also address how the DM programs will coordinate with MCO case management activities, in particular for members who would benefit from both.

(2) Member Identification Strategies

The MCO must have a systematic method of identifying and enrolling eligible members in each DM program. This shall include but not be limited to:

- (a) Members who have reached the service threshold for inpatient hospital services (see Section 2-3.2).
- (b) Members who have reached the service threshold for other non-inpatient hospital services (see Section 2-3.2) and could potentially benefit from enrollment in a disease management program.
- (c) Members who meet the requirements at 2-7.1.e(6)(c) regarding excessive and/or inappropriate Emergency Department Utilization who could potentially benefit from enrollment in a disease management program.
- (d) Members who have reached the service threshold for inpatient hospital services shall be enrolled in either a disease management program or MCO case management, whichever the CONTRACTOR determines is more appropriate.

The MCO must operate each program using an “opt out” methodology, meaning that services will be provided to eligible members unless they specifically ask to be excluded. The Bureau may elect to mandate the eligibility criteria the MCO must use if the program evaluation does not demonstrate the desired effect and/or if the Bureau determines that the criteria in use are overly restrictive.

(3) Program Content

The MCO must adopt clinical practice guidelines that serve as the basis for each DM program. The guidelines must be evidence-based and formally adopted by the QI or other clinical committee. The guidelines must be distributed to practitioners who are likely to use them and must be made available to the Bureau upon request. Upon enrollment in the DM program, the MCO must provide information to the member and practitioner regarding how to use the services and specific information to the practitioner concerning how the program works with the practitioner’s patients. MCOs must provide

primary care providers with a list of their patients enrolled in each program upon initial enrollment and at least annually thereafter.

Each DM program must be based on a treatment plan that serves as the outline for all of the activities/interventions in the program. At a minimum the activities/interventions associated with the treatment plan must address condition monitoring, patient adherence to the treatment plan, consideration of other co-morbidities, and condition-related lifestyle issues. The Bureau may elect to mandate an intervention strategy the MCO must employ if the program evaluation does not demonstrate the desired effect and/or if the Bureau determines that the interventions are suboptimal.

(4) Stratification

As part of the DM programs, the CONTRACTOR shall classify eligible members into stratification levels according to condition severity or other clinical or member-provided information. The DM programs shall tailor the program content, education activities, and benchmarks and goals for each risk level.

(5) CONTRACTOR's Program Description

Annually, on July 1, the CONTRACTOR shall submit a description of its Disease Management Program that shall include the following:

1. Definition of the target population for each program and the method used to identify and enroll members; and
2. Written description of the stratification levels for each of the four (4) programs, including member criteria and associated interventions.

(6) Informing and Educating Members

The DM programs shall educate members and/or their caregivers regarding their particular condition(s) and needs. This information shall be provided upon enrollment in the DM program. The DM programs shall educate members to increase their understanding of their condition(s), the factors that impact their health status (e.g., diet and nutrition, lifestyle, exercise, medication compliance), and to empower members to be more effective in self-care and management of their health so they:

- (a) Are proactive and effective partners in their care;
- (b) Understand the appropriate use of resources needed for their care;
- (c) Identify precipitating factors and appropriate responses before they require more acute intervention; and
- (d) Are compliant and cooperative with the recommended treatment plan.

(7) Informing and Educating Providers

As part of the DM programs, the CONTRACTOR shall educate providers regarding the guidelines and shall distribute the guidelines to providers who are likely to treat enrollees with the DM conditions. This includes, but is not limited to, PCPs and specialists involved in treating that particular condition. The CONTRACTOR shall also provide each PCP with a list of their patients enrolled in each DM program upon the member's initial enrollment and at least annually thereafter. The CONTRACTOR shall provide specific information to the provider concerning how the program(s) works. The DM's

provider education shall be designed to increase the providers' adherence to the guidelines in order to improve the members' conditions.

(8) Program Evaluation

The CONTRACTOR shall establish measurable benchmarks and goals for each DM program and shall evaluate the programs using these benchmarks and goals. These benchmarks and goals shall be specific to each condition but should include the following information. This information shall be reported to TENNCARE annually on July 1st in accordance with Section 2-10.13.7.

- (a) The total number of active enrollees having one or more of the diagnosis codes (ICD-9 Codes) relating to each of the required DM programs;
- (b) The active participation rate (as defined by NCQA) for each of the required DM programs, including the numerator and denominator used in calculating the rate
- (c) The number of individuals participating in each level or stratification of each of the DM programs;
- (d) Performance measured against at least two important aspects of the clinical practice guidelines associated with each DM program;
- (e) The rate of emergency department utilization and inpatient hospitalization for members with diabetes, asthma and congestive heart failure (rate calculations must be shown);
- (f) Neonatal Intensive Care Unit (NICU) days for births associated with members enrolled in the Maternity Management Program;
- (g). HEDIS measures related to any of the four DM projects; and
- (h). Any other performance measure associated with any of the four DM programs that the MCO has chosen to track.

17. Section 2-8 shall be deleted and replaced in its entirety so that the new Section 2-8 shall read as follows:

2-8. Complaints and Appeals

Members shall have the right to file appeals regarding adverse actions taken by the CONTRACTOR. For purposes of this requirement, appeal shall mean a member's right to contest verbally or in writing, any adverse action taken by the CONTRACTOR to deny, reduce, terminate, delay or suspend a covered service as well as any other acts or omissions of the CONTRACTOR which impair the quality, timeliness, or availability of such benefits. An appeal may be filed by the member or by a person authorized by the member to do so, including but not limited to, a provider with the member's written consent. Complaint shall mean a member's right to contest any other action taken by the CONTRACTOR or service provider other than those that meet the definition of an adverse action. The CONTRACTOR shall inform members of their complaint and appeal rights in the member handbook in compliance with the requirements in Section 2-6.2.c.1. The CONTRACTOR shall have internal complaint and appeal procedures for members in accordance with TennCare rules and regulations, the TennCare waiver, consent decrees, or court orders governing the appeals process.

The CONTRACTOR shall devote a portion of its regularly scheduled QM/QI committee meetings, as described in Section 2-9.8., to the review of member complaints and appeals that have been received.

The CONTRACTOR shall ensure that punitive action is not taken against a provider who files an appeal on behalf of a member with the member's written consent, supports a member's appeal, or certifies that a member's appeal is an emergency appeal and requires an expedited resolution in accordance with TennCare policies and procedures.

2-8.a. Appeals

The CONTRACTOR's appeal process shall include, at a minimum, the following:

- 2-8.a.1. The CONTRACTOR shall have a contact person who is knowledgeable of appeal procedures and direct all appeals, whether the appeal is verbal or the member chooses to file in writing, to TENNCARE. Should an enrollee choose to appeal in writing, the enrollee will be instructed to file via mail or fax to the designated TENNCARE P. O. Box or fax number for medical appeals.
- 2-8.a.2. The CONTRACTOR shall have sufficient support staff (clerical and professional) available to process appeals in accordance with TennCare requirements related to the appeal of adverse actions affecting a TennCare member. The CONTRACTOR shall notify TENNCARE of the names of appointed staff members and their phone numbers. Staff shall be knowledgeable about applicable state and federal law, TennCare rules and regulations, and all court orders and consent decrees governing appeal procedures, as they become effective.
- 2-8.a.3. The CONTRACTOR shall educate its staff concerning the importance of the appeals procedure, the rights of the member, and the time frames in which action must be taken by the CONTRACTOR regarding the handling and disposition of an appeal.
- 2-8.a.4. The CONTRACTOR shall identify the appropriate individual or body within the plan having decision-making authority as part of the appeal procedure.
- 2-8.a.5. The CONTRACTOR shall have the ability to take telephone appeals and accommodate persons with disabilities during the appeals process. Appeal forms shall be available at each service site and by contacting the CONTRACTOR. However, members shall not be required to use a TENNCARE approved appeal form in order to file an appeal.
- 2-8.a.6. Upon request, the CONTRACTOR shall provide members a TENNCARE approved appeal form(s).
- 2-8.a.7. The CONTRACTOR shall provide reasonable assistance to all appellants during the appeal process.
- 2-8.a.8. At any point in the appeal process, TENNCARE shall have the authority to remove a member from the CONTRACTOR's MCO when it is determined that such removal is in the best interest of the Member and TENNCARE.
- 2-8.a.9. The Contractor shall require providers to display notices of member's right to appeal adverse actions affecting services in public areas of each facility in accordance with TennCare rules and regulations. The Contractor shall ensure that providers have correct and adequate supply of public notices.
- 2-8.a.10. Neither the CONTRACTOR nor TENNCARE shall prohibit or discourage any individual from testifying on behalf of a member.
- 2-8.a.11. The CONTRACTOR shall ensure compliance with all notice requirements and notice content requirements specified in applicable state and federal law, TennCare rules and

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regulations, and all court orders and consent decrees governing notice and appeal procedures, as they become effective.

- 2-8.a.12. TENNCARE may develop additional appeal process guidelines or rules, including requirements as to content and timing of notices to members, which shall be followed by the CONTRACTOR. However, the CONTRACTOR shall not be precluded from challenging any judicial requirements and to the extent judicial requirements that are the basis of such additional guidelines or rules are stayed, reversed or otherwise rendered inapplicable, the CONTRACTOR shall not be required to comply with such guidelines or rules during any period of such inapplicability.
- 2-8.a.13 The CONTRACTOR shall provide general and targeted education to providers regarding expedited appeals(described in TennCare rules and regulations), including when an expedited appeal is appropriate, and procedures for providing written certification thereof.
- 2-8.a.14. The CONTRACTOR shall require providers to provide written certification regarding whether a member's appeal is an emergency upon request by a member prior to filing such appeal, or upon reconsideration of such appeal by the CONTRACTOR when requested by TENNCARE.
- 2-8.a.15. The CONTRACTOR shall provide notice to contract providers regarding provider responsibility in the appeal process, including but not limited to, the provision of medical records and/or documentation as described in Section 2-9.7.
- 2-8.a.16. The CONTRACTOR shall urge providers who feel they cannot order a drug on the TennCare Preferred Drug List (PDL) to seek prior authorization in advance, as well as to take the initiative to seek prior authorization or change or cancel the prescription when contacted by a member or pharmacy regarding denial of a pharmacy service due to system edits (i.e., therapeutic duplication, etc.)
- 2-8.a.17. Member eligibility and eligibility-related grievances and appeals, including termination of eligibility, effective dates of coverage, and the determination of premium and co-payment responsibilities shall be directed to the Department of Human Services.

If it is determined by TENNCARE that violations regarding the appeal guidelines have occurred by the CONTRACTOR, TENNCARE shall require that the CONTRACTOR submit and follow through with a corrective action plan. Failure to comply with the appeal guidelines issued by TENNCARE, including an acceptable corrective action plan, shall result in the CONTRACTOR being subject to liquidated damages as described in Section 6-8. of this Contract.

- 18. Section 2-9.3 shall be amended by adding a new 8 and renumbering the existing 2-9.3.8 through 2.9.3.13 accordingly, including all references thereto, so that the new Section 2-9.3.8 shall read as follows:

- 8. The CONTRACTOR shall maintain a 1-800 Nurse Triage line that shall be available to members 24 hours a day, seven days a week. The 24/7 Nurse Triage line service shall provide health information/education to patients; healthcare counseling/telephone triage to assess health status in order to steer patients to the appropriate level of care. The 24/7 Nurse Triage line shall assure effective patient management by avoiding over-utilization in inappropriate settings. The CONTRACTOR shall include information on the Nurse Triage line, including the telephone number and the services/information available by calling the line, in the member handbook and in quarterly member newsletters.

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19. Section 2-9.8.6 shall be amended by adding a new second paragraph so that the amended Section 2-9.8.6 shall read as follows:

6. Credentialing and Recredentialing

The CONTRACTOR utilizes current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent practitioners with whom it contracts or employs and who fall within its scope of authority and action. The CONTRACTOR shall further adhere to the credentialing requirements described in Section 2-4.7.6 of this Contract regarding non-contract providers.

The CONTRACTOR shall completely process credentialing applications within thirty (30) calendar days of receipt of a completed, including all necessary documentation and attachments, credentialing application. Completely process shall mean that the CONTRACTOR shall review, approve and load approved applicants to their provider files in their claims processing system or deny the application and assure that provider is not included in the CONTRACTOR's network.

20. Section 2-9 shall be amended by adding a new 10 and renumbering the existing 10 through 13 as well as all references thereto, so that the new Section 2-9.10 shall read as follows:

2-9.10. Subrogation (Casualty) Recovery

The CONTRACTOR shall conduct diagnosis and trauma code editing to identify potential subrogation related claims. This editing should identify claims with a diagnosis of 800.00 thru 999.99 (excluding 994.6) or a claim submitted with an accident trauma indicator of 'Y'. TENNCARE approved questionnaires or other type TENNCARE approved forms shall be used to gather data and information pertinent to potential subrogation cases. TENNCARE shall determine a threshold amount for which a subrogation case should be pursued.

21. The renumbered Section 2-9.14.a.4 shall be deleted in its entirety and replaced by a new Section 2-9.14.a.4 which shall read as follows:

4. The CONTRACTOR shall promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud and abuse. Unless prior approval is obtained from the agency to whom the incident was reported, or to another agency designated by the agency that received the report, after reporting fraud or suspected fraud and/or suspected abuse and/or confirmed abuse, , the CONTRACTOR shall not take any of the following actions as they specifically relate to TennCare claims:

- i. contact the subject of the investigation about any matters related to the investigation,
- ii. enter into or attempt to negotiate any settlement or agreement regarding the incident, or
- iii. accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident. .

22. Section 2-10.2.1 shall be amended by adding new text to the end of the existing text so that the amended Section 2-10.2.1 shall read as follows:

2-10.2.1. Enrollee Information, Weekly Reporting

The CONTRACTOR shall submit weekly reports in an electronic format, unless otherwise specified or approved by TENNCARE in writing, which shall serve as the source of information for a change in the enrollee's TennCare information. Such information shall serve as the source of

information for a change in the enrollee's address and/or selection of MCO plan. This report shall include enrollees who move outside the CONTRACTOR's service area as well as enrollees who move to a new address within the CONTRACTOR's service area. The CONTRACTOR agrees to work with the State to devise a methodology to use returned mail to identify enrollees who have moved and whose whereabouts is unknown.

Within ninety (90) days of the time that TENNCARE develops and describes to the CONTRACTOR the new reporting procedures, the CONTRACTOR shall also be required to include in the report, described above, any information which is known by the CONTRACTOR that may affect an enrollee's TennCare eligibility and/or cost sharing responsibilities including changes in income, family size, access to health insurance, third party resources including any known insurance policies and/or legal actions, proof of uninsurability including limited coverage and exclusionary riders to policies, whether or not the enrollee is incarcerated, or resides outside the State of Tennessee. The minimum data elements that will be required for this report can be found in Attachment XII, Exhibit A of this Contract.

The CONTRACTOR shall gather, store and update a minimum of the following health insurance information:

- Recipient SSN
- Type of Coverage (Inpatient, outpatient, pharmacy, dental, vision, etc.)
- Policyholder name
- Policyholder SSN, if available
- Policyholder's relationship to the recipient
- TennCare Carrier Number, Carrier name and address, if available
- Policy number
- Begin and end dates of policy.

Health insurance data provided by the CONTRACTOR that does not include the above required fields will be returned to the CONTRACTOR.

23. Section 2-10.3.1 shall be deleted and replaced in its entirety so that the amended Section 2-10.3.1 shall read as follows:

2-10.3.1 Monthly Provider Enrollment File

The CONTRACTOR shall furnish to TENNCARE at the beginning of the Agreement period an electronic report in the format specified by TENNCARE listing all providers enrolled in the TennCare plan, including but not limited to, physicians, dentists, hospitals, home health agencies, pharmacies, medical vendors, ambulance, etc. This listing shall include regularly enrolled providers, specialty or referral providers and any other provider, which may be enrolled for purposes of payment for services provided out-of-plan. The minimum data elements required for all provider listings required in this Section may be found in Attachment XII, Exhibit C of this Agreement. The CONTRACTOR shall be required to inquire as to the provider's race and/or national origin and shall report to TENNCARE the information, if any, furnished by the provider in response to such an inquiry. The CONTRACTOR shall be prohibited from requiring the provider to declare race and/or national origin and shall not utilize information regarding race or national origin obtained pursuant to such request as a basis for decisions regarding participation in the CONTRACTOR's provider network or in determination of compensation amounts.

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Thereafter, a complete electronic provider replacement file (full file refresh) shall be submitted on a monthly basis by the 5th of each month. This information shall be used to determine CONTRACTOR compliance with network adequacy standards and shall be used in conjunction with encounter data.

Each provider shall be identified by a Tennessee Medicaid I.D. number (i.e., each servicing provider in a group or clinic practice must be identified by a separate provider number). This unique identifier shall appear on all encounter data transmittals.

Within ten (10) working days of a request by TENNCARE, the CONTRACTOR shall provide an unduplicated listing of all contracted providers, in a format designated by TENNCARE.

Failure to report the provider information, as specified above, shall result in the application of liquidated damages as described in Section 6.7.2 of this Agreement.

24. Section 2-10.5.3 shall be deleted in its entirety and replaced by a new Section 2-10.5.3 which shall read as follows:

3. Reporting Provider Payment Issues

(a) If the CONTRACTOR does not automatically credit TENNCARE for receivables within ninety (90) calendar days, the CONTRACTOR shall determine the extent of the collection effort required based on the table below. This table identifies the minimum collection threshold for cumulative receivable balances. All collection efforts shall be clearly documented.

Receivable Balance	Collection Attempts		Forwarded to Collections
	45 Day	90 Day	
< \$10	None Required		
\$10 - \$49.99	✓		
\$50 - \$99.99	✓	✓	
\$100 - Over	✓	✓	✓
Responsibility	MCC		TENNCARE

The first notice shall occur by day forty-five (45) and may be in the form of notice in a remittance advice or a demand memo; however, the ninety (90) day notice must be made using a demand memo. Each of these notices shall be sent within five (5) business days of becoming due.

Additional collection attempts by the CONTRACTOR are not necessary if a collection notice is returned because the provider has gone out-of-business or has declared bankruptcy for the period the receivable was established. This circumstance must be reported in the "Uncollectible Accounts Report" as described below.

Failure to send the notices as scheduled may result in liquidated damages as described in Section 6-8 of this Contract.

(b) If the CONTRACTOR does not automatically credit TENNCARE for aged accounts within sixty (60) calendar days, the CONTRACTOR shall submit to TENNCARE, within ten (10) business days following the end of the month, an "Aged Accounts Receivable report". The effective date of this report shall be the last Friday of the previous month. The report shall have an easily identifiable date, contain a total report balance, and

provide <30, 30, 60, 90, and >120 calendar day balances. Although only totals are required, the CONTRACTOR may report aging balances at the account level. If the CONTRACTOR is not reporting at the account level, the CONTRACTOR shall have the capability to identify the detail that makes up a total if necessary.

- (c) If the CONTRACTOR does not automatically credit TENNCARE for uncollectible accounts within ninety (90) calendar days, the CONTRACTOR shall submit to TENNCARE, within ten (10) business days following the end of the month, an "Uncollectible Accounts Report", in a format described by TENNCARE, for accounts meeting the following criteria:

- (1) the account proves to be uncollectible after 120 calendar days, or
- (2) the provider account owner has gone out-of-business, or
- (3) the provider account owner has declared bankruptcy.

In addition to the "Uncollectible Accounts Report" report, the CONTRACTOR shall submit scanned copies of returned envelopes or legal documents referencing providers that have gone out-of-business and/or declared bankruptcy.

- (d) The Contractor shall provide TENNCARE a report, in a format described by TENNCARE, detailing all checks remitted to providers, enrollees or vendors on behalf of the State which remain outstanding (which have not been cashed) greater than one hundred eighty (180) calendar days. Reports are due monthly within fifteen (15) business days after the end of the month.

Failure to report outstanding checks to TENNCARE as described above may result in liquidated damages as described in Section 6-8 of this Contract.

25. Section 2-10.10.8 shall be deleted and replaced in its entirety so that the amended Section 2-10.10.8 shall read as follows:

2-10.10.8 Cost and Utilization Reports

- a. The CONTRACTOR shall report Cost and Utilization information for: Groups 1.A and 1.B; Group 2; and for all other Groups by TennCare enrollee eligibility category as described in Attachment XII, Exhibits L.1 through L.5 and as required below. CONTRACTOR shall submit a written explanation for how service data will be mapped to the categories identified in said Exhibits by August 1, 2002. These reports shall be maintained in an Excel spreadsheet format and shall be sent via e-mail to TENNCARE on a quarterly basis, based on incurred date, with a ninety (90) day lag and shall be due to TENNCARE one hundred five (105) calendar days following the quarter for which the CONTRACTOR is reporting.

1. Attachment XII, Exhibits L.1 through L.5 shall be submitted for each quarter on a "Cumulative Year to Date" basis.
2. Attachment XII, Exhibits L.1 through L.5 shall be submitted for each quarter on a "Rolling Twelve (12) Month" basis. Please note that the aggregated payment information of these reports for certain reporting periods should be reasonably tied to the CONTRACTOR's MSBT reports, and invoices/encounters submitted by the CONTRACTOR for the comparable periods.

- b. In order to support federal reporting requirements, the CONTRACTOR shall provide the Cost and Utilization information specified in Attachment XII, Exhibits L.1 through L.5, separately for

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individuals who are dually eligible for Medicaid and Medicare in response to an adhoc request from TennCare in accordance with the timeframes specified in Section 6-8.

26. Section 2-10.13.3 shall be amended by adding “or prior to enrollee’s beginning effective date” before “on a quarterly basis” in the first sentence so that the amended Section 2-10.13.3 shall read as follows:

2-10.13.3. PCP Assignment

The CONTRACTOR shall submit a report to TENNCARE including the total number of enrollees and percentage of total enrollees in each Grand Region that have not been assigned to a primary care provider (PCP) within thirty (30) days of enrollment or prior to enrollee’s beginning effective date, on a quarterly basis. This report shall be submitted electronically.

27. Section 2-10.13.7 shall be deleted and replaced in its entirety so that the amended Section 2-10.13.7 shall read as follows:

2-10.13.7. Disease Management Reports

- (a) The CONTRACTOR shall submit a quarterly *Disease Management Update Report* that includes, for each disease management program as described in Section 2-7.1.f, a brief narrative description of the program, the total number of members in the program, the total number of members enrolled and disenrolled during the quarter, and a description of the specific provider and member interventions performed during the quarter. The report shall be submitted in a format prescribed by TENNCARE.
- (b) Annually on July 1st, the CONTRACTOR shall submit a *Disease Management Report* that includes, the information specified in 2-7.1.f (5) and (8). The report shall be submitted in a format prescribed by TENNCARE.

28. Section 2-10 shall be amended by adding a new Section 2-10.18 which shall read as follows:

2-10.18. Benefits/Service Requirements and Limits Reports

The CONTRACTOR shall submit a quarterly *Service Threshold Report* in the format prescribed by TENNCARE. At minimum, the report shall include: the number of members who reached each service threshold; confirmation that all members who reached the service threshold for mandatory enrollment in MCO case management or a disease management program were enrolled; the number of members who reached the service threshold for evaluation of appropriateness for enrollment in MCO case management or disease management who were evaluated for enrollment; the number of those members evaluated who were enrolled in MCO case management or disease management (by program); and the number of those members who were evaluated but not enrolled in MCO case management or disease management by reason.

29. Section 2-18.ee shall be amended by deleting “non-emergency” so that the amended Section 2-18.ee shall read as follows:

2-18.ee. Specify that the TennCare Provider Independent Review of Disputed Claims process shall be available to providers to resolve claims denied in whole or in part by the MCO as provided at T.C.A. 56-32-226(b).

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- 2-18. ff. Include a conflict of interest clause as stated in subsections (a) and (c) of Section 6-7, Gratuities clause as stated in 6-11 and Lobbying clause as stated in 6-12 of this Contract between the CONTRACTOR and TENNCARE;
30. Section 2-24.i shall be amended by adding a new sentence to the end so that the amended Section 2-24.i shall read as follows:
- 2-24.i. On an annual basis, the CONTRACTOR's Title VI Compliance Plan and Assurance of Non-discrimination. The signature date of the CONTRACTOR's Title VI Compliance Plan is to coordinate with the signature date of the CONTRACTOR's Assurance of Non-discrimination Compliance.
31. Section 2-25 shall be amended by adding a new subsection e which shall read as follows:
- e. Payments to the Meharry Medical Services Foundation and/or the Meharry Dental Clinic under this amendment shall not exceed \$13,000,000 for State fiscal year 2007. In addition to any interest earned, TENNCARE agrees to pay the CONTRACTOR a sum sufficient to administer this amendment in accordance with state law. The total obligation to the CONTRACTOR under this amendment including the supplemental payment to Meharry Medical Services Foundation and/or the Meharry Dental Clinic shall not exceed \$13,265,306 for State fiscal year 2007. At such time that Federal Regulations allow, TENNCARE may discontinue making supplemental pool payments through the CONTRACTOR during State fiscal year 2007.
32. Section 2-26 shall be amended by adding a new subsection e which shall read as follows:
- e. Payments to the critical access hospitals under this amendment shall not exceed \$10,000,000 for State fiscal year 2007. In addition to any interest earned, TENNCARE agrees to pay the CONTRACTOR a sum sufficient to administer this amendment in accordance with state law. The total obligation to the CONTRACTOR under this amendment including the payments to the hospitals shall not exceed \$10,204,082 for State fiscal year 2007. At such time that Federal Regulations allow, TENNCARE may discontinue making supplemental pool payments through the CONTRACTOR during State fiscal year 2007.
33. Section 2-27 shall be amended by adding a new subsection b which shall read as follows:
- a. Upon notice by TENNCARE, the Contractor will pay each provider the Quarterly Payment Due presented in the schedule provided by TENNCARE each quarter (period covering July 1, 2006 through June 30, 2007) of the State's fiscal year. The amount of quarterly payments may vary. The actual payment amount for each quarter will be provided by TENNCARE and will be based on the disbursement methodology recommended by TENNCARE's actuaries. Disbursements to providers by the CONTRACTOR, under this amendment, shall not exceed **\$100,000,000**, as presented in the schedule provided by TENNCARE. In addition to any interest earned, TENNCARE agrees to pay the CONTRACTOR a sum sufficient to administer this amendment in accordance with state law. Payments to the CONTRACTOR, under this amendment, will not exceed **\$102,040,816**.
34. Section 2-28.b and c shall be deleted and replaced in their entirety so that the amended Section 2-28 shall read as follows:

Community Health Record

Amendment Number 15 (cont.)

- a. Contractor Responsibility for Community Health Record. Effective July 1, 2005, VSHP shall receive all data to be contained in the CHR. VSHP will provide a health maintenance module within the CHR which captures individual progress toward receiving targeted preventive health interventions for their cohort (i.e. EPSDT requirements for children and youth). The module helps clinicians recognize opportunities for educational and preventative healthcare services for their patients at the point of care. VSHP will link all of this data based on an Enterprise Master Person Index (EMPI). The EMPI provides a central repository for person-centric data from a variety of contributing systems. EMPI facilitates the integrity of a single person record. The mission of the EMPI is to provide the functionality for the end-user to find the right person and the right information at the right time. Additionally, the EMPI provides a solution to identify and eliminate as many duplicate records as possible.
- b. Community Health Record Deliverables. Effective July 1, 2005, version 1.0 of the CHR shall be available to TENNCARE for VSHP contracted providers and all enrollees assigned to BlueCare/TennCare Select. Enrollees may opt out in which case the enrollee's information will be omitted from view through the CHR. The CHR shall include the following enrollee information:
- Patient Demographics
 - Primary Care Physicians (PCPs) identified
 - Claimed visit information from claims detail
 - Medication information from claims detail
 - State immunization information
 - Lab data information from claims detail
 - Interactivity by the provider through EPSDT (TenderCare) documentation to include 16 age specific forms complying with current periodicity
- c. Community Health Record Electronic Prescribing Function

Beginning no later than October 31, 2005, as a component of the Community Health Record function of TennCare Select, the Contractor shall begin making available to VSHP contracted providers the following electronic prescribing functionality to allow for prescribing medications:

- Eligibility
- Formulary information
- Drug to drug compatibility
- Drug to allergy checking
- Dose range checking based on predetermined characteristics including age, height, weight and additional attributes
- Member and provider education as regards co-pays and total costs differentials for brand names versus generic utilization
- Appropriate therapeutic substitution
- Step care progression relevant to clinical process

Effective no later than September 1, 2006, VSHP shall make available the current version of the Community Health Connection to all TennCare providers for the entire TennCare population, with the exception of enrollees who opt out, not to exceed 1.3 million members. Prior to September 1, 2006, VSHP shall commence comprehensive communication, marketing and outreach programs to providers to maximize the number of providers who utilize the Shared Health System. VSHP shall target a 10% provider adoption rate by TennCare providers no later than nine (9) months following the implementation of all TennCare enrollees of 3rd Quarter 2006; 16% in Year 2 and 25% in Year 3.

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Further guidance, including but not limited to, timeframes and procedural requirements will be provided in the memorandum of understanding between the State and Shared Health.

d. Cooperation with Regional Health Information Organizations

Consistent with the state's objectives to further electronic community health record efforts more broadly, VSHP and its sub-contractors shall, in keeping with the obligations and goals of this agreement, cooperate with contracted Regional Health Information Organizations as directed by TennCare.

e. Use of Community Health Record Information

The CONTRACTOR agrees that all information, including but not limited to, studies, draft manuscripts, etc., to be used for any other purpose than to fulfill the obligations of this Contract shall be submitted to TENNCARE for review and written, expressed approval prior to its release and/or use.

35 Section 5-1.b., c., i and j shall be deleted in their entirety and replaced by new Sections 5-1.b., c., i and j which shall read as follows:

b. Effective January 1, 2003, the administrative fee paid for enrollees in Group 1.A, Group 1.B and Group 2 shall be \$25.00 per member per month. Effective July 1, 2006, the administrative fee paid for enrollees in Group 1.A, Group 1.B and Group 2 shall be \$25.20 per member per month.

c. Effective January 1, 2003, the administrative fee paid for enrollees in Group 3, Group 4, Group 5 and Group 6 shall vary based on the total number of enrollees in these groups as follows:

Enrollment Level	Administrative Fee
0 to 99,999 enrollees	\$11.37
100,000 to 199,999 enrollees	\$11.25
200,000 to 299,999 enrollees	\$11.12
300,000 to 399,999 enrollees	\$11.00
400,000 to 499,999 enrollees	\$10.89
500,000 to 599,999 enrollees	\$10.68
600,000 to 699,999 enrollees	\$10.53
700,000 to 799,999 enrollees	\$10.38
800,000 to 899,999 enrollees	\$10.23
900,000 to 999,999 enrollees	\$10.08
1,000,000 or more enrollees	\$9.93

Effective July 1, 2006, the administrative fee paid for enrollees in Group 3, Group 4, Group 5 and Group 6 shall vary based on the total number of enrollees in these groups as follows:

Enrollment Level	Administrative Fee
0 to 99,999 enrollees	\$11.57
100,000 to 199,999 enrollees	\$11.45
200,000 to 299,999 enrollees	\$11.32
300,000 to 399,999 enrollees	\$11.20
400,000 to 499,999 enrollees	\$11.09
500,000 to 599,999 enrollees	\$10.88
600,000 to 699,999 enrollees	\$10.73
700,000 to 799,999 enrollees	\$10.58
800,000 to 899,999 enrollees	\$10.43
900,000 to 999,999 enrollees	\$10.28
1,000,000 or more enrollees	\$10.13

Amendment Number 15 (cont.)

- 11.32
- i. The applicable administrative fee shall be determined based upon the total number of enrollees in the month preceding the month in which payment is made to the Contractor as determined by TENNCARE. The administrative fee specified shall be applicable to all enrollees in Group 3, Group 4, Group 5 and Group 6 upon attainment of an enrollment level. For example, if enrollment for the month of February is 250,000 enrollees, the administrative fee payment for the month of March shall be \$11.12 per member per month for each Group 3, Group 4, Group 5 and Group 6 enrollee assigned to the CONTRACTOR during the month of March, adjusted as set forth in subparagraphs 5-1.d through 5-1.j, if applicable.
 - i. Effective July 1, 2005 through August 31, 2006, VSHP shall provide all services required to maintain the CHR, EPSDT documentation and reporting analytics as related to said CHR as defined above, at no additional charge to the TennCare Bureau. Effective July 1, 2006 through June 30, 2007, VSHP shall be reimbursed an administration fee for maintaining and providing the CHR of \$1.20 PMPM for enrollees participating in the CHR. TENNCARE shall not reimburse the additional \$1.20 PMPM for enrollees who opt out and are omitted from the CHR. Upon sixty (60) calendar days prior written notice, the State may terminate the services to be provided under this section of this agreement with or without cause, and/or for convenience. Upon provision of said notice and at the conclusion of the sixty (60) calendar day notice period VSHP's obligation to provide necessary services to maintain the CHR will end and the State shall have no further obligation to reimburse the \$1.20 PMPM administration fee.
 - j. Pay-for-Performance Administrative Fee for Disease Management (DM)
 1. Depending of the level of performance, the CONTRACTOR may earn up to \$0.12 pmpm in the form of a supplemental administrative fee for disease management.

On July 1, 2006, the CONTRACTOR will be eligible for an additional \$0.03 pmpm, applied to member months from the period of July 1, 2005 to June 30, 2006, if their HEDIS 2006 HbA1c testing rate is at or above the 50th percentile for Medicaid HEDIS 2005, as reported by NCQA. In addition, on July 1, 2006, the CONTRACTOR will be eligible for an additional \$0.03 pmpm, applied to member months from the period of July 1, 2005 to June 30, 2006, if their HEDIS 2006 Prenatal Care rate is at or above the 75th percentile for Medicaid HEDIS 2005, as reported by NCQA.

On December 31, 2006, the CONTRACTOR will report the following ED utilization data to TENNCARE:

1. Emergency department visits with a diagnosis of asthma divided by total number of enrollees in the MCO with a diagnosis of asthma, multiplied by 1000 for the time periods July 1 – September 30 in calendar year 2005 and in calendar year 2006.
2. Emergency department visits with a diagnosis of congestive heart failure divided by total number of enrollees in the MCO with a diagnosis of congestive heart failure, multiplied by 1000 for the time periods July 1 – September 30 in calendar year 2005 and in calendar year 2006.

Emergency Department visits shall include all ER visits even if the visit results in a 23 Hour Observation or an inpatient stay. Include Emergency Department visits whether or not an actual payment to the provider was made for the services.

The CONTRACTOR will be eligible for an additional \$0.03 pmpm, applied to member months from the period of January 1, 2006 to December 31, 2006, if the ED visit rate per 1000 for asthma has decreased by at least 5% from 2005. Similarly, the CONTRACTOR will be eligible for an additional \$0.03 pmpm, applied to member months from the period of January 1, 2006 to

Amendment Number 15 (cont.)

December 31, 2006, if the ED visit rate per 1000 for congestive heart failure has decreased by at least 5% from 2005.

Beginning on July 1, 2007, the supplemental administrative fee will be referred to as a Quality Incentive and will be based on HEDIS, CAHPS and/or utilization criteria specified by TennCare and assessed annually. The CONTRACTOR will be advised of the specific methodology that will be used for the July 1, 2007 supplemental fee determination, by September 1, 2006.

The CONTRACTOR's eligibility for the supplemental administrative fee payment described in this Section shall not adjust the base administrative fee described elsewhere in this Section 5-1 of this Contract for effective dates not described in this Section 5-1.j.

36. Section 5-3.a shall be amended by adding new text so that the amended Section 5-3.a shall read as follows:

- a. **Medical Services Payments.** The CONTRACTOR shall assure that payments are not issued to providers that have not obtained a Tennessee Medicaid provider number or for which disclosure requirements have not been obtained by the CONTRACTOR in accordance with 42 CFR 455.100 through 106 and Section 2-18 of this Contract. The CONTRACTOR shall prepare checks for payment on a periodic basis. The CONTRACTOR shall notify the State of the amount to be paid in a mutually acceptable form and substance at least 72 hours in advance of distribution of provider checks. The amount to be paid shall be reduced by the amount of third party recoveries captured in the claims processing system. The State shall release funds in the amount to be paid to providers to the CONTRACTOR. Funds shall be released within 72 hours of receipt of notice. In turn, the CONTRACTOR shall release payments to providers within 24 hours of receipt of funds from the State and provide TENNCARE with a check register or similar document that is generated from the managed care claims processing system supporting the release of these payments by no later than seven (7) calendar days after the CONTRACTOR's request of the funds.

For each request related to payments to providers through the CONTRACTOR's claims processing system, the CONTRACTOR shall provide a claims data extract in a format and media described by TENNCARE to support the payments released to providers. The CONTRACTOR should provide a reconciliation for the total paid amounts between the funds released for payment to providers, the supporting claims data extract, and the encounter data submissions for the relevant adjudication cycle. The reconciliation should be submitted within seven (7) days of the claims data extract.

Upon notification by TENNCARE, funds released to the CONTRACTOR for purposes of provider payments shall be made based on the CONTRACTOR's encounter data. TENNCARE shall implement this process by initially making payments based on all encounters and providing the CONTRACTOR an error report of unacceptable encounter records. The final phase of implementation shall result in TENNCARE releasing funds based on clean encounters only. Once TENNCARE releases funds based solely on clean encounter data, the CONTRACTOR will no longer be required to submit the claims data extract. The reconciliation and check register must continue to be submitted on a weekly basis for the previous weeks check release.

The CONTRACTOR shall pursue and report on providers which maintain an accounts-payable balance or maintain outstanding checks in accordance with Section 2-10.1 of this Agreement.

37. Section 6-7 shall be deleted and replaced in its entirety so that the amended Section 6-7 shall read as follows:

6-7. Conflict of Interest

- (a) The CONTRACTOR warrants that no part of the total Contract amount provided herein shall be paid directly or indirectly to any officer or employee of the State of Tennessee as wages, compensation, or gifts in exchange for acting as officer, agent, employee, subcontractor, or consultant to the CONTRACTOR in connection with any work contemplated or performed relative to this Contract unless otherwise authorized by the Commissioner, Tennessee Department of Finance and Administration. The authorization may be requested in writing to the Commissioner of Finance and Administration. (See 45 CFR 93.100 *et seq.*, 31 USC 1352, TCA 3-6-101 *et seq.*, 3-6-201 *et seq.*, 3-6-301 *et seq.*, and 8-50-505.)
- (b) By December 31 of each year disclosure shall be made by the CONTRACTOR to the Deputy Commissioner of the Bureau of TennCare, Department of Finance and Administration in writing. The disclosure shall include the following:
 - 1. A list of any officer or employee of the State of Tennessee who receives wages or compensation in connection with work performed under this Contract;
 - 2. A statement of the reason or purpose for the wages or compensation; and
 - 3. A statement that the Commissioner of Department of Finance and Administration has authorized this arrangement.
- (c) This Contract may be terminated by TENNCARE if it is determined that the CONTRACTOR, its agents or employees offered or gave gratuities of any kind to any officials or employees of the State of Tennessee. The CONTRACTOR certifies that no member of or delegate of Congress, the United States General Accounting Office, DHHS, CMS, or any other federal agency has or will benefit financially or materially from this Contract.

The CONTRACTOR shall include the substance of this clause in all subcontracts and provider agreements.

- 38. The Liquidated Damages chart of Program Issues in Section 6-8.b.2 shall be deleted and replaced in its entirety so that the amended Chart of Liquidated Damages shall read as follows:

CLASS	PROGRAM ISSUES	DAMAGE
A.1	Failure to comply with claims processing as described in Section 2-9.7 of this Agreement	\$10,000 per month, for each month that TENNCARE determines that the CONTRACTOR is not in compliance with the requirements of Section 2-9.7 of this Agreement.
A.2	Failure to comply with licensure requirements in Section 2-9.4 of this Contract	\$5,000 per calendar day that staff/provider/agent/subcontractor is not licensed as required by applicable state law plus the amount paid to the staff/provider/agent/subcontractor during that period

Amendment Number 15 (cont.)

A.3	Failure to respond to a request by DCS or TENNCARE to provide service(s) to a child in DCS custody or at risk of entering DCS custody as described in Section 3 of this Agreement	\$1000 per occurrence
A.4	Failure to comply with obligations and timeframes in the delivery of EPSDT screens and related services	\$1000 per occurrence
A.5	Denial of a request for services to a child in DCS custody or at risk of entering DCS custody when the services have been reviewed and authorized by the TENNCARE Chief Medical Officer	\$1000 per occurrence
A.6	Failure to provide a service or make payments for a service within five (5) calendar days of a reasonable and appropriate directive from TENNCARE to do so or upon approval of the service or payment by the CONTRACTOR during the appeal process, or within a longer period of time which has been approved by TENNCARE upon a plan's demonstration of good cause.	\$500 per day beginning on the next calendar day after default by the plan in addition to the cost of the services not provided.
A.7	Failure to provide proof of compliance to the Bureau Office of Contract Compliance and Performance within five (5) calendar days of a reasonable and appropriate directive from TennCare or within a longer period of time which has been approved by TENNCARE upon a plan's demonstration of Good Cause.	\$500 per day beginning on the next calendar day after default by the plan.
A.8	Failure to comply with this Agreement and federal rules/law regarding Sterilizations/Abortions/Hysterectomies as outlined in Section 2-3.11 of this Agreement	\$500 per violation or the actual amount of the federal penalty created by this violation, whichever is greater.
A.9	Failure to provide coverage for prenatal care without a delay in care and in accordance with the terms of this Agreement	\$500 per day, per occurrence, for each day that care is not provided in accordance with the terms of this Agreement.
A.10	Failure to comply with the notice requirements of the TENNCARE rules and regulations or any subsequent amendments thereto, and all court orders governing appeal	\$500 per occurrence in addition to \$500 per calendar day for each calendar day required notices are late or deficient or for each calendar day beyond the required time frame that the appeal is

	procedures, as they become effective.	unanswered in each and every aspect and/or each day the appeal is not handled according to the provisions set forth by this Agreement or required by TENNCARE
A.11	Failure to provide continuation or restoration of services where enrollee was receiving the service as required by the TENNCARE rules or any subsequent amendments thereto, all applicable state or federal law, and all court orders governing appeal procedures as they become effective.	An amount sufficient to at least offset any savings the CONTRACTOR achieved by withholding the services and promptly reimbursing the enrollee for any costs incurred for obtaining the services at the enrollee's expense. \$500 per day for each calendar day beyond the 2 nd business day after an On Request Report regarding a member's request for continuation of benefits is sent by TENNCARE.
A.12	Failure to forward an expedited appeal to TENNCARE in twenty-four (24) hours or a standard appeal in five (5) days.	\$500 per calendar day.
A.13	Failure to provide complete documentation, including medical records, and comply with the timelines for responding to a medical appeal as set forth in TennCare rules and regulations and all court orders and consent decrees governing appeals procedures as they become effective.	\$500 per calendar day for each calendar day beyond the required time frame that the appeal is unanswered in each and every aspect and/or each day the appeal is not handled according to the provisions set forth by this Contract or required by TENNCARE.
A.14	Failure to submit a timely corrected notice of adverse action to TENNCARE for review and approval prior to issuance to the member.	\$1,000 per occurrence if the notice remains defective plus a per calendar day assessment in increasing increments of \$500 (\$500 for the first day, \$1,000 for the second day, \$1,500 for the third day, etc.) for each day the notice is late and/or remains defective.
A.15	Per the Revised Grier Consent Decree, "Systemic problems or violations of the law" (e.g., a failure in 20% or more of appealed cases over a 60-day period) regarding any aspect of medical appeals processing pursuant to TennCare rules and regulations and all court orders and consent decrees governing appeal procedures, as they become effective.	First occurrence: \$500 per instance of such "systemic problems or violations of the law", even if damages regarding one or more particular instances have been assessed (in the case of "systemic problems or violations of the law" relating to notice content requirements, \$500 per notice even if a corrected notice was issued upon request by TENNCARE). Damages per instance shall increase in \$500 increments for each subsequent "systemic problem or violation of the law" (\$500 per instance the first time a

Amendment Number 15 (cont.)

		<p>“systemic problem or violation of the law” relating to a particular requirement is identified; \$1,000 per instance for the 2nd time a “systemic problem or violation of the law” relating to the same requirement is identified; etc.)</p>
A.16	<p>Systemic violations regarding any aspect of the requirements in accordance with this Contract and the TennCare rules and regulations.</p>	<p>First occurrence: \$500 per instance of such systemic violations, even if damages regarding one or more particular instances have been assessed.</p> <p>Damages per instance shall increase in \$500 increments for each subsequent systemic violation (\$500 per instance the first time a systemic violation relating to a particular requirement is identified; \$1,000 per instance for the 2nd time a systemic violation relating to the same requirement is identified; etc.)</p>
A.17	<p>Failure to adhere to ED guidelines as described in Section 2-7.1.e of this Contract.</p>	<p>\$1000 per occurrence for each failure to enroll a member identified per 2-7.1.e in active case management.</p> <p>\$5000 per occurrence for each failure to assist a member in arranging care in an alternative setting per 2-7.1.e (7) or (8).</p>
A.18	<p>Failure to 1) provide an approved service timely, i.e., in accordance with timelines specified in the Special Terms and Conditions for Access in the TennCare Waiver or Attachment III, or when not specified therein, with reasonable promptness; or 2) issue appropriate notice of delay with documentation upon request of ongoing diligent efforts to provide such approved service.</p>	<p>The cost of services not provided plus \$500 per day, per occurrence, for each day 1) that approved care is not provided timely; or 2) notice of delay is not provided and/or the MCC fails to provide upon request sufficient documentation of ongoing diligent efforts to provide such approved service.</p>
B.1	<p>Failure to report Specialty listings to PCP providers as required by this Agreement</p>	<p>\$500 per calendar day.</p>
B.2	<p>Failure to complete or comply with corrective action plans as required by TENCARE</p>	<p>\$500 per calendar day for each day the corrective action is not completed or complied with as required.</p>
B.3	<p>Failure to seek, collect and/or report third party recoveries to TENNCARE.</p>	<p>\$500 per day for each calendar day that TENNCARE determines the CONTRACTOR is not making reasonable effort to seek and collect third party recoveries.</p>

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B.4	Deadlines for Achieving NCQA Accreditation	Termination of the Agreement for Breach as described in Section 6-2 for consistent failure to meet the deadlines described in Section 2-9.8.7 of this Agreement.
B.5	Failure to submit Audited HEDIS and CAHPS Reports Annually by June 15 th as described in Section 2-9. 8.7 and 2-10.13.4	\$250 per day for every calendar day reports are late.
B.6	Failure to submit NCQA Accreditation Report as described in Sections 2-9.8.7 and 2-10.13.6	\$500 per day for every calendar day beyond the 10 th calendar day Accreditation Status is not reported.
B.7	Failure to comply with Conflict of Interest, Lobbying, and Gratuities requirements described in Section 6-7, 6-11 or 6-12.	110% of the total amount of compensation paid by the CONTRACTOR to inappropriate individuals as described in Section 6-7, 6-11 or 6-12 and possible termination of the Agreement as described in 6-7, 6-11 or 6-12.
B.8	Failure to submit TennCare Disclosure of Lobbying Activities Form by CONTRACTOR	\$1000.00 per day that disclosure is late
B.9	Failure to comply with Offer of Gratuities constraints described in Section 6-11	110 % of the total benefit provided by the CONTRACTOR to inappropriate individuals and possible termination of the Agreement for Breach as described in 6-2 of this Agreement.
B.10	Failure to obtain approval of Marketing Materials.	\$500 per day for each calendar day that TENNCARE determines the CONTRACTOR has provided enrollee material that has not been approved by TENNCARE.
B.11	Failure to comply with Marketing timeframes for providing Member Handbooks, I.D. cards, Provider Directories, and Newsletters.	\$5000 for each occurrence.
B.12	Failure to achieve and/or maintain financial reserves in accordance with TCA.	\$500 per calendar day for each day that financial requirements have not been met.
B.13	Failure to submit the CONTRACTOR's annual NAIC filing as described in Section 2.10.8.	\$500 per calendar day.
B.14	Failure to submit the CONTRACTOR's quarterly NAIC filing as described in Section 2.10.8.	\$500 per calendar day.
B.15	Failure to submit audited financial statements as described in Section 2.10.8.	\$500 per calendar day.

Amendment Number 15 (cont.)

B.16	Failure to comply with fraud and abuse provisions as described in Section 2-9.13 of this Contract.	\$500 per calendar day for each day that the CONTRACTOR does not comply with fraud and abuse provisions described in Section 2-9.13 of this Contract.
B.17	Failure to send collection notices to providers as described in 2-10.5.3(a) of this Agreement.	\$100 per provider notice per month.
B.18	Failure to send detailed reports to TENNCARE as described in 2-10.5.3(b), (c) and (d) of this Contract.	\$500 per day for each day that report is late.
B.19	Failure to require and assure compliance with Ownership and Disclosure requirements.	\$5000 per provider disclosure/attestation for each disclosure/attestation that is not received or is received and signed by a provider that does not request or contain complete and satisfactory disclosure of the requirements outlined in 42 CFR 455, Subpart B.
B.20	Failure to maintain a complaint and appeal system as required in Section 2-8 of this Contract.	\$500 per calendar day
B.21	Failure to maintain required insurance as required in Section 2-20 of this Contract.	\$500 per calendar day
B.22	Imposing arbitrary utilization guidelines or other quantitative coverage limits as prohibited in Section 2-3.3 and 2-7.1 of this Contract.	\$500 per occurrence.
B.23	Failure to completely process a credentialing application within thirty (30) calendar days of receipt of a completed, including all necessary documentation and attachments, credentialing application as required in Section 2-4.7.6 and 2-9.8.6 of this Contract.	\$5000 per application that has not been approved and loaded into the CONTRACTOR's system or denied within thirty (30) calendar days of receipt of a completed credentialing application. And/Or \$1000 per application per day for each day beyond thirty (30) calendar days that a completed credentialing application has not been completed as described in Section 2-3.k.6 and 2-9.j.6 of this Contract.
B.24	Failure to maintain provider agreements in accordance with Section 2-18 of this Contract.	\$5000 per provider agreement found to be non-compliant with the requirements outlined in Section 2-18 of this Contract.

C.1	Failure to comply in any way with staffing requirements as described in Section 2-9 of this Agreement	\$250 per calendar day for each day that staffing requirements as described in Section 2-9 of this Agreement are not met.
C.2	Failure to report provider notice of termination of participation in the CONTRACTOR's plan	\$200 per day.
C.3	Failure to address or resolve problems with individual encounter records in a timely manner as required by TENNCARE.	An amount equal to the paid amount of the individual encounter record(s) that was rejected or, in the case of capitated encounters, the fee-for-service equivalent thereof as determined by TENNCARE.

39. Section 6-12 shall be deleted and replaced in its entirety so that the amended Section 6-12 shall read as follows:

6-12. Lobbying

The CONTRACTOR certifies by signing this Contract, to the best of its knowledge and belief, that federal funds have not been used for lobbying in accordance with 45 CFR Part 93 and 31 USC 1352. (See also TCA 3-6-101 *et seq.*, 3-6-201 *et seq.*, 3-6-301 *et seq.*, and 8-50-505.).

The CONTRACTOR shall disclose any lobbying activities using non-federal funds in accordance with 45 CFR Part 93.

Failure by the Contractor to comply with the provisions herein shall result in termination of the Contract and/or liquidated damages as provided in 6-8.b.2 (B.7, B.8 and B.9) of this Contract.

40. Attachment II shall be deleted in its entirety and shall now read "Left Blank Intentionally".
41. Attachment XII, Exhibit C shall be deleted and replaced in its entirety and shall read as follows:

**ATTACHMENT XII, EXHIBIT C
REQUIRED DATA ELEMENTS FOR PROVIDER ENROLLMENT REPORTING**

This provider listing shall include, at a minimum, the following data elements:

1. Provider name;
2. Provider address, including the address of all service sites operated by the provider (a P.O. Box is not acceptable);
3. Tax/Employer I.D. number (EIN) or Provider social security;
4. Provider's race and/or national origin;
5. Provider Specialty 1 and Specialty 2;
6. Provider license number and type of license (if applicable);

Amendment Number 15 (cont.)

7. Tennessee Medicaid Provider I.D. Number for the individual provider being enrolled (Should correspond to the Provider Name) .;
8. Unique Individual MCC Provider I.D. Number (Should correspond to the Provider Name);
9. Medicare I.D. number, if applicable (Should correspond to the Provider Name);
10. Initial Credentialing Date;
11. Recredentialing Date (This date must reflect the actual date recredentialing completed);
12. Provider telephone number (including area code) for each provider service site (up to 6 phone numbers);
13. Provider's Drug Enforcement Agency (DEA) number (if applicable);
14. Begin date of participation and end date of participation (if applicable);
15. Contracted Provider versus Non-Contracted Provider Indicator (single case agreements are considered Non-Contracted Providers);
16. Indicate whether or not the following services are provided by the provider: Obstetrics, General Surgery, Pediatrics, or EPSDT;
- 17.. Is the provider board certified;
18. The provider's service delivery county of practice; and
19. Indicate whether or not the provider's practice is limited to male or female patients;
20. Date disclosure form/attestation signed by provider;

For Dentists and Primary Care Providers (PCP) the following additional data elements are required:

21. Is the Dental / PCP's practice closed to new TennCare members as primary care patients;

For Primary Care Providers (PCPs only) the following additional data elements are required:

22. Does the PCP deliver babies;
23. Does the PCP provide prenatal care;
24. What is the youngest age each individual PCP will accept as a patient into the PCP's practice? (Age zero (00) equates to providing services to newborns);
25. What is the oldest age each individual PCP will accept as a patient into the PCP's practice? (Age 99 equates to Age 99 and older); and
26. How many members has the MCO assigned to each individual PCP for primary care service delivery?

Amendment Number 15 (cont.)

42. Attachment XII, Exhibits L.1 through L.3 shall be amended by deleting the words "Cumulative Year to Date" from the Header of each reporting format.
43. This Contract shall be amended by deleting the words "Office of Contract Development and Compliance (OCDC)" and replacing them with "Office of Contract Compliance and Performance (OCCP)".

Amendment Number 15 (cont.)

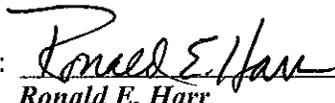
All of the provisions of the original Contract not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective July 1, 2006 or as of the date it is approved by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

VOLUNTEER STATE HEALTH PLAN, INC.

BY: 
M. D. Goetz, Jr.
Commissioner

BY: 
Ronald E. Harr
President and Chief Executive Officer

DATE: 6/23/06

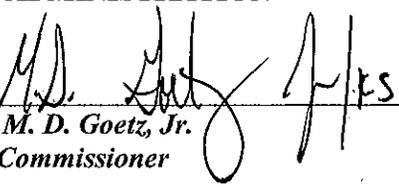
DATE: June 21, 2006

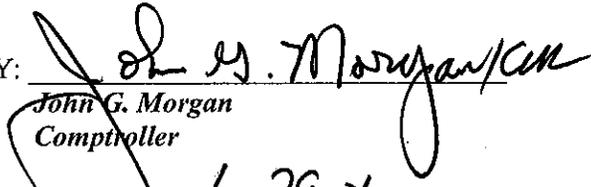
APPROVED BY:

APPROVED BY:

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

**STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY**

BY: 
M. D. Goetz, Jr.
Commissioner

BY: 
John G. Morgan
Comptroller

DATE: JUN 26 2006

DATE: 6-29-06

CONTRACT SUMMARY SHEET

RFS Number:	318.66-026	Contract Number:	FA-02-14632-14
State Agency:	Department of Finance and Administration	Division:	Bureau of TennCare

Contractor	Contract Identification Number
VSHP (TennCare Select)	<input type="checkbox"/> V- <input type="checkbox"/> C-

Service Description

Managed Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medicaid Population

Contract Begin Date	Contract End Date
7/1/2001	12/31/2006

Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66	532	134	11	<input type="checkbox"/> STARS		
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)	
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$	18,599,868.48
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$	33,079,942.80
2004	\$ 25,125,990.72	\$ 38,364,165.90			\$	63,490,156.62
2005	\$ 58,007,447.00	\$ 58,007,447.00			\$	116,014,894.00
2006	\$87,748,111.00	\$87,748,111.00				\$175,496,222.00
2007	\$29,003,723.50	\$29,003,723.50				\$58,007,447.00
Total:	\$222,426,332.85	\$ 242,262,198.05				\$464,688,530.90

OCR RELEASED
MAY 01 2006
TO ACCOUNTS

CFDA#	93.778 Title XIX Dept. of Health & Human Svcs.	Check the box ONLY if the answer is YES:
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State Fiscal Contract		
Name:	Scott Pierce	Is the Contractor a SUBRECIPIENT? (per OMB A-133)
Address:	Great Circle Road 310	Is the Contractor a Vendor? (per OMB A-133)
Phone:	Nashville, TN (615)507-6415	Is the Fiscal Year Funding STRICTLY LIMITED?
Procuring Agency Budget Officer Approval Signature		Is the Contractor on STARS?
Scott Pierce		Is the Contractor's FORM W-9 ATTACHED?
		Is the Contractor's Form W-9 Filed with Accounts?

COMPLETE FOR ALL AMENDMENTS (only)			Funding Certification
	Base Contract & Prior Amendments	This Amendment ONLY	
CONTRACT END DATE:	12/31/2006		Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.
FY: 2002	\$ 18,599,868.48		
FY: 2003	\$ 33,079,942.80		
FY: 2004	\$ 63,490,156.62		
FY: 2005	\$116,014,894.00		
FY: 2006	\$172,434,996.00	\$3,061,226.00	
FY: 2007	\$58,007,447.00		
Total:	\$ 461,627,304.90	\$3,061,226.00	

OCR
APR 27 2006
RECEIVED

AMENDMENT NUMBER 14

**AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.**

CONTRACT NUMBER: FA-02-14632-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Amended and Restated Contractor Risk Agreement (CRA) by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and VOLUNTEER STATE HEALTH PLAN, INC., hereinafter referred to as the CONTRACTOR as specified below.

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

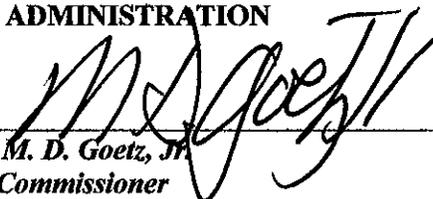
1. Part d. of Section 2-25 shall be amended by deleting 10,000,000 and replacing it with 13,000,000 so that the amended Section 2-25.d shall read as follows:
 - d. Payments to the Meharry Medical Services Foundation and/or the Meharry Dental Clinic under this amendment shall not exceed \$13,000,000 for State fiscal year 2006. In addition to any interest earned, TENNCARE agrees to pay the CONTRACTOR a sum sufficient to administer this amendment in accordance with state law. The total obligation to the CONTRACTOR under this amendment including the supplemental payment to Meharry Medical Services Foundation and/or the Meharry Dental Clinic shall not exceed \$13,265,306 for State fiscal year 2006. At such time that Federal Regulations allow, TENNCARE may discontinue making supplemental pool payments through the CONTRACTOR during State fiscal year 2006.

Amendment Number 14 (cont.)

All of the provisions of the original Agreement not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective as of the date it is approved by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

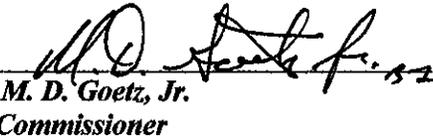
**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

BY: 
M. D. Goetz, Jr.
Commissioner

DATE: _____

APPROVED BY:

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

BY: 
M. D. Goetz, Jr.
Commissioner

DATE: 4/27/06

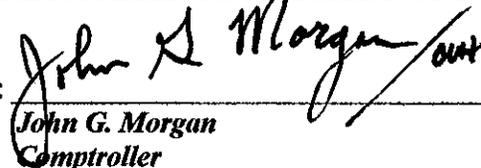
VOLUNTEER STATE HEALTH PLAN, INC.

BY: 
Ronald E. Harr
President and Chief Executive Officer

DATE: April 10, 2006

APPROVED BY:

**STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY**

BY: 
John G. Morgan
Comptroller

DATE: 4-28-06

CONTRACT SUMMARY SHEET

RFS Number:	318.66-026	Contract Number:	FA-02-14632-13
State Agency:	Department of Finance and Administration	Division:	Bureau of TennCare

Contractor	Contract Identification Number
VSHP (TennCare Select)	<input type="checkbox"/> V- <input type="checkbox"/> C-

Service Description

Managed Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medicaid Population

Contract Begin Date	Contract End Date
7/1/2001	12/31/2006

Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66	532	134	11	<input type="checkbox"/> STARS		
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)	
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$ 18,599,868.48	
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$ 33,079,942.80	
2004	\$ 25,125,990.72	\$ 38,364,165.90			\$ 63,490,156.62	
2005	\$ 58,007,447.00	\$ 58,007,447.00			\$ 116,014,894.00	
2006	\$86,217,498.00	\$86,217,498.00			\$172,434,996.00	
2007	\$29,003,723.50	\$29,003,723.50			\$58,007,447.00	
Total:	\$220,895,719.85	\$ 240,731,585.05			\$ 461,627,304.90	

OCR RELEASED

MAR 1 2006

TO ACCOUNTS

CFDA# 93.778 Title XIX Dept. of Health & Human Svcs.	Check the box ONLY if the answer is YES:
State Fiscal Contract	Is the Contractor a SUBRECIPIENT? (per OMB A-133)
Name: Scott Pierce 310	Is the Contractor a Vendor? (per OMB A-133)
Address: Great Circle Road	Is the Fiscal Year Funding STRICTLY LIMITED?
Phone: Nashville, TN (615)507-6415	

Procuring Agency Budget Officer Approval Signature	Is the Contractor on STARS?
Scott Pierce	Is the Contractor's FORM W-9 ATTACHED?
	Is the Contractor's Form W-9 Filed with Accounts?

COMPLETE FOR ALL AMENDMENTS (only)			Funding Certification	
	Base Contract & Prior Amendments	This Amendment ONLY	Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.	
CONTRACT END DATE:	12/31/2006			
FY: 2002	\$ 18,599,868.48			
FY: 2003	\$ 33,079,942.80			
FY: 2004	\$ 63,490,156.62			
FY: 2005	\$116,014,894.00			
FY: 2006	\$116,014,894.00	\$56,420,102.00		
FY: 2007	\$58,007,447.00			
Total:	\$ 405,207,202.90	\$56,420,102.00		

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 2006 MAR 28 AM 11:05
 COMPTROLLER'S OFFICE
 OFFICE OF
 MANAGEMENT SERVICES

OCR

MAR 27 2006

RECEIVED

AMENDMENT NUMBER 13

**AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.**

CONTRACT NUMBER: FA-02-14632-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as follows:

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. The Pharmacy Benefit described in Sections 2-3.1.1 and 2 shall be amended by adding clarification of Medicare Part D coverage effective January 1, 2006 so that the amended Pharmacy Benefits shall read as follows:

2-3.1.1

<p>Pharmacy Services (obtained directly from an ambulatory retail pharmacy setting, outpatient hospital pharmacy, mail order pharmacy or those administered to a long-term care facility resident (nursing facility))</p>	<p>As medically necessary. Non-covered therapeutic classes as described in Section 2-3.q, DESI, LTE, IRS drugs excluded.</p> <p>Effective July 1, 2000 through December 31, 2005, TENNCARE is responsible (whether directly or through a PBM) for the provision and payment of pharmacy benefits to individuals who are enrolled in the TennCare Program in the category of TennCare Medicaid/Medicare dual eligible. (However, this does not include pharmaceuticals administered in a doctor's office.)</p> <p>TENNCARE is not responsible for the provision and payment of pharmacy services for TennCare Medicaid/Medicare dual eligibles prior to the date that TENNCARE has notified the CONTRACTOR through the regular electronic eligibility update that these individuals are eligible in the TennCare/Medicare dual eligible category.</p> <p>Effective July 1, 2003, the aforementioned covered pharmacy services shall be provided by the Pharmacy Benefits Manager (PBM) contracted by the TENNCARE Bureau. Pharmacies providing home infusion drugs and biologics only (not including services) shall bill the PBM.</p> <p>Diabetic monitors and supplies as well as injectable drugs obtained directly from a pharmacy provider shall be included in the covered pharmacy services that will be provided by the TennCare Pharmacy Benefit Manager effective July 1, 2003.</p>
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Amendment 13 (cont.)

	<p>The CONTRACTOR shall be responsible for reimbursement of injectable drugs obtained in an office/clinic setting in accordance with benefits described herein and to providers providing both home infusion services and the drugs and biologics. Effective July 1, 2005, the CONTRACTOR shall require that all home infusion claims contain NDC coding and unit information to be paid.</p> <p>Effective August 1, 2005, unless the CONTRACTOR is otherwise notified by TENNCARE, the Benefit Limits for Pharmacy coverage, as provided by the PBM shall be as follows:</p> <p>Non-Institutionalized Mandatory and Optional (other than Medically Needy) Medicaid Adults (Age 21 and older) and Pregnant Medically Needy Adults (Age 21 and older): 5 Prescriptions per Month of which only 2 may be Brand name</p> <p>Institutionalized Medicaid Adults (Age 21 and older): As medically necessary</p> <p>Medically Needy Non-Institutionalized, Non-Pregnant Adults (Age 21 and older): Non-covered.</p> <p>Standard Eligible, Age 21 and older: Non-covered</p> <p>Medicaid/Standard Eligible, Under age 21: As medically necessary</p> <p>Effective January 1, 2006, provision and payment of pharmacy benefits to individuals who are enrolled in the TennCare Program in the category of TennCare Medicaid/Medicare dual eligible shall be administered by Medicare Part D.</p>
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2-3.1.2

<p>Pharmacy Services</p>	<p>Pharmacy services shall be provided by the Pharmacy Benefits Manager (PBM), unless otherwise described below.</p> <p>Non-Institutionalized Mandatory and Optional (other than Medically Needy) Medicaid Adults (Age 21 and older) and Medically Needy Adults (Age 21 and older): 5 Prescriptions per Month of which only 2 may be Brand name</p> <p>Institutionalized Medicaid Adults (Age 21 and older): As medically necessary</p> <p>Standard Eligible, Age 21 and older: Non-covered</p> <p>Medicaid/Standard Eligible, Under age 21: As medically necessary</p>
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Amendment 13 (cont.)

	<p>NOTE:</p> <p>Certain drugs (known as DESI, LTE, or IRS drugs) are excluded from coverage.</p> <p>Limits on Pharmacy benefits as well as the effective dates thereof are subject to change based on Waiver and/or Court negotiations.</p> <p>Effective July 1, 2003, the aforementioned covered pharmacy services shall be provided by the Pharmacy Benefits Manager (PBM) contracted by the TENNCARE Bureau. Pharmacies providing home infusion drugs and biologics <u>only (not including services)</u> shall bill the PBM.</p> <p>Diabetic monitors and supplies as well as injectable drugs obtained directly from a pharmacy provider shall be included in the covered pharmacy services that will be provided by the TennCare Pharmacy Benefit Manager effective July 1, 2003.</p> <p>CONTRACTOR RESPONSIBILITIES:</p> <p>The CONTRACTOR shall be responsible for reimbursement of injectable drugs obtained in an office/clinic setting in accordance with benefits described herein and to providers providing both home infusion services and the drugs and biologics. Effective July 1, 2005, the CONTRACTOR shall require that all home infusion claims contain NDC coding and unit information to be paid.</p> <p>Services reimbursed by the CONTRACTOR shall not be included in the Pharmacy Benefit Limits as described above.</p> <p>Effective January 1, 2006, provision and payment of pharmacy benefits to individuals who are enrolled in the TennCare Program in the category of TennCare Medicaid/Medicare dual eligible shall be administered by Medicare Part D.</p>
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2. Section 2-26 shall be amended by deleting and replacing item d so that the new item d shall read as follows:
 - d. Payments to the critical access hospitals under this amendment shall not exceed \$10,000,000 for State fiscal year 2006. In addition to any interest earned, TENNCARE agrees to pay the CONTRACTOR a sum sufficient to administer this amendment in accordance with state law. The total obligation to the CONTRACTOR under this amendment including the payments to the hospitals shall not exceed \$10,204,082 for State fiscal year 2006. At such time that Federal Regulations allow, TENNCARE may discontinue making supplemental pool payments through the CONTRACTOR during State fiscal year 2006.

3. Part a of Section 2-27 shall be deleted and replaced in its entirety so that the amended Section 2-27.a shall read as follows:
 - a. Upon notice by TENNCARE, the Contractor will pay each provider the Quarterly Payment Due presented in the schedule provided by TENNCARE each quarter (period covering July 1, 2005

Amendment 13 (cont.)

through June 30, 2006) of the State's fiscal year. The amount of quarterly payments may vary. The actual payment amount for each quarter will be provided by TENNCARE and will be based on the disbursement methodology recommended by TENNCARE's actuaries. Disbursements to providers by the CONTRACTOR, under this amendment, shall not exceed **\$150,000,000**, as presented in the schedule provided by TENNCARE. In addition to any interest earned, TENNCARE agrees to pay the CONTRACTOR a sum sufficient to administer this amendment in accordance with state law. Payments to the CONTRACTOR, under this amendment, will not exceed **\$153,061,224**.

All of the provisions of the original Contract not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective as of the date it is approved by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

BY: M. D. Goetz, Jr.
M. D. Goetz, Jr.
Commissioner

DATE: 3/22/06

APPROVED BY:

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

BY: M. D. Goetz, Jr.
M. D. Goetz, Jr.
Commissioner

DATE: 3/27/06

VOLUNTEER STATE HEALTH PLAN, INC.

BY: Ronald E. Harr
Ronald E. Harr
President and Chief Executive Officer

DATE: Mar. 9, 2006

APPROVED BY:

**STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY**

BY: John G. Morgan
John G. Morgan
Comptroller

DATE: 3-30-06

CONTRACT SUMMARY SHEET

RFS Number:	318.66-026	Contract Number:	FA-02-14632-12
State Agency:	Department of Finance and Administration	Division:	Bureau of TennCare

Contractor	Contract Identification Number
VSHP (TennCare Select)	<input type="checkbox"/> V- <input type="checkbox"/> C-

Service Description

Managed Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medicaid Population

Contract Begin Date	Contract End Date
7/1/2001	12/31/2006

Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66	532	134	11	<input type="checkbox"/> STARS		
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)	
2002	\$ 6,755,937.23	\$ 11,843,931.25	<div style="font-size: 2em; opacity: 0.5;">OCR RELEASED</div> <div style="font-size: 1.5em; opacity: 0.5;">JAN 05 2006</div> <div style="font-size: 2em; opacity: 0.5;">TO ACCOUNTS</div>		\$	18,599,868.48
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$	33,079,942.80
2004	\$ 25,125,990.72	\$ 38,364,165.90			\$	63,490,156.62
2005	\$ 58,007,447.00	\$ 58,007,447.00			\$	116,014,894.00
2006	\$ 58,007,447.00	\$ 58,007,447.00				\$116,014,894.00
2007	\$ 29,003,723.50	\$ 29,003,723.50				\$58,007,447.00
Total:	\$ 192,685,668.85	\$ 212,521,534.05				\$

CFDA# 93.778 Title XIX Dept. of Health & Human Svcs.	Check the box ONLY if the answer is YES:
--	--

State Fiscal Contract		
Name:	Scott Pierce	310
Address:	Great Circle Road	
Phone:	Nashville, TN (615)507-6415	
Procuring Agency Budget Officer Approval Signature		
Scott Pierce		
		Is the Contractor a SUBRECIPIENT? (per OMB A-133)
		Is the Contractor a Vendor? (per OMB A-133)
		Is the Fiscal Year Funding STRICTLY LIMITED?
		Is the Contractor on STARS?
		Is the Contractor's FORM W-9 ATTACHED?
		Is the Contractor's Form W-9 Filed with Accounts?

COMPLETE FOR ALL AMENDMENTS (only)			Funding Certification	
	Base Contract & Prior Amendments	This Amendment ONLY	Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.	
CONTRACT END DATE:	12/31/2005	12-31-06		
FY: 2002	\$ 18,599,868.48			
FY: 2003	\$ 33,079,942.80			
FY: 2004	\$ 63,490,156.62			
FY: 2005	\$116,014,894.00			
FY: 2006	\$55,335,500.00	\$60,679,394.00		
FY: 2007		\$58,007,447.00		
Total:	\$ 286,520,361.90	\$118,686,841.00		

RECEIVED

2006 JAN -3 AM 9:34
 COMPTROLLER'S OFFICE
 OFFICE OF
 MANAGEMENT SERVICES

AMENDMENT NUMBER 12

AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.

CONTRACT NUMBER: FA-02-14632-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as follows:

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. TennCare's address for notices described in Section 1-1 shall be deleted and replaced by the current address and shall read as follows:

If to TENNCARE:

Deputy Commissioner
Bureau of TennCare
310 Great Circle Road
Nashville, Tennessee 37243

2. Section 1-3 is amended by adding a new definition for "Office of Inspector General" and "TENNCARE Representatives", deleting the definition of "Program Integrity" and deleting and replacing the definitions for "Medical Records", "State", "Tennessee Bureau of Investigation, Medicaid Fraud Control Unit" and "TennCare Standard Enrollee" so that the amended definitions shall read as follows:

Medical Records - All medical histories; records, reports and summaries; diagnoses; prognoses; records of treatment and medication ordered and given; X-ray and radiology interpretations; physical therapy charts and notes; lab reports; other individualized medical documentation in written or electronic format; and analyses of such information.

Office of Inspector General (OIG) - The Office of Inspector General investigates and may prosecute civil and criminal fraud and abuse of the TennCare program or any other violations of state law related to the operation of TennCare administratively, civilly or criminally.

State - The State of Tennessee, including, but not limited to, any entity or agency of the state, such as the Department of Finance and Administration, the Office of Inspector General, the Department of Mental Retardation, the Bureau of TennCare, the Medicaid Fraud Control Unit, the Department of Mental Health and Developmental Disabilities, the Department of Children's Services, the Department of Health, the TennCare Division within the Department of Commerce and Insurance and the Office of the Attorney General.

TennCare - The program administered by the single state agency, as designated by the state and CMS, pursuant to Title XIX of the Social Security Act and the Section 1115 research and demonstration waiver granted to the state of Tennessee and any successor programs.

Amendment 12 (cont.)

TENNCARE Representatives - The State of Tennessee and any entity authorized by statute or otherwise to act on behalf of the State of Tennessee in administering and/or enforcing the terms of this Contract. Such entity(s) may include, but are not limited to, the TennCare Bureau, the Department of Health, the Department of Finance and Administration, the Department of Mental Health and Mental Retardation, the TennCare Division within the Tennessee Department of Commerce and Insurance, the Office of Inspector General and the Tennessee Bureau of Investigation, Medicaid Fraud Control Unit.

TennCare Standard Enrollee – an enrollee who qualifies and has been determined eligible for benefits in the TennCare program through eligibility criteria designated as “TennCare Standard” as described in the approved TennCare waiver beginning on July 1, 2002, and as amended by CMS on March 24, 2005 and the TennCare Rules and Regulations.

Tennessee Bureau of Investigation, Medicaid Fraud Control Unit (TBI MFCU) – The Tennessee Bureau of Investigation’s Medicaid Fraud Control Unit has the authority to investigate and prosecute (or refer for prosecution) violations of all applicable state and federal laws pertaining to fraud in the administration of the Medicaid program, the provision of medical assistance, the activities of providers of medical assistance in the state Medicaid program (TennCare), allegations of abuse or neglect of patients in health care facilities receiving payments under the state Medicaid program, misappropriation of patients’ private funds in such facilities, and allegations of fraud and abuse in board and care facilities.

3. Section 2-1.h shall be deleted and replaced in its entirety so that the amended Section 2-1.h shall read as follows:
 - h. Comply with clear and measurable Provider Network, Claims Processing, Financial/Actuarial, Clinical/Quality and Member/Provider service standards of accountability defined by NCQA Standards and Guidelines, TENNCARE and as specified in this Contract.
4. Section 2-1.m shall be amended by deleting the sixth sentence so that the amended Section 2-1.m shall read as follows:
 - m. Agree to report all provider related data required pursuant to this Contract to TENNCARE using a uniform provider number (i.e., All MCOs must transmit each provider related record to TENNCARE using the same provider identification number regardless of which or how many MCOs the provider participates in). The uniform number to be reported for all providers except pharmacy will be the traditional “Medicaid” provider number. Prior to payment of a claim, the MCO shall require that providers that have not been enrolled in the TennCare Program previously as a Medicaid provider or as a provider who currently receives direct payment from TENNCARE (i.e., Medicare cost sharing) contact the Medicaid/TennCare Provider Enrollment Unit and obtain a “Medicaid” provider number. The issuance of a provider number by TennCare is simply for the purpose of establishing a common provider number for reporting purposes as required by this Section and does not imply any enrollment in the TennCare program or that TENNCARE has credentialed the provider or convey any other contractual relationship or any other responsibility with the provider. Pharmacy providers shall use the National Association Board of Pharmacy (NABP) number that has been assigned. CONTRACTOR agrees that at such time that the Centers for Medicare & Medicaid Services establishes a national uniform identification number, at the State’s request, the CONTRACTOR shall agree to utilize CMS’s newly established uniform provider numbers for all provider reporting purposes in accordance with timeframes established by CMS;
5. Section 2-2.t shall be deleted and replaced in its entirety so that the amended Section 2-2.t shall read as follows:
 - 2-2.t. The CONTRACTOR shall complete all necessary requirements to implement changes and process accurately all information necessary to successfully implement the Reform changes in accordance with state or federal law, rule or policy, including but not limited to benefit limits, cost sharing or copays or

Amendment 12 (cont.)

any other program change for which the MCO provides services. These changes shall be defined by TENNCARE. The CONTRACTOR agrees to test Reform changes prior to October 1, 2005. TENNCARE shall require the CONTRACTOR to track and report accumulated benefit information effective January 1, 2006; however, benefit limits shall not be imposed on enrollees prior to July 1, 2006 as described in Section 2-3.1.2 of this Contract. Further, the CONTRACTOR shall adhere to the effective dates of the changes as described in Section 2-3.1 of this Contract. Failure to successfully test and implement reform changes, as determined by TENNCARE, shall be considered breach of this Contract and the CONTRACTOR may be subject to termination in accordance with Section 6-2.b of this Contract;

6. Sections 2-3.1, 2-3.1.1 and 2-3.1.2 shall be deleted in their entirety and replaced by new Sections 2-3.1, 2-3.1.1 and 2-3.1.2 which shall read as follows:

2-3.1. TennCare Covered Benefits Chart

Effective July 1, 2006, benefits in the TennCare Program as provided by the CONTRACTOR are based on specified eligibility categories.

The CONTRACTOR shall cover, at a minimum, the services and benefits as outlined below.

2-3.1.1 TennCare Benefits, prior to July 1, 2006:

SERVICE	BENEFIT
Inpatient Hospital Services	As medically necessary.
Outpatient Hospital Services	As medically necessary.
Physician Inpatient Services	As medically necessary. This shall include acupuncture performed by a Physician or a registered nurse as an anesthetic in connection with a surgical procedure.
Physician Outpatient Services/Community Health Clinic Services/Other Clinic Services	As medically necessary. This shall include acupuncture performed by a Physician or a registered nurse as an anesthetic in connection with a surgical procedure and services provided by a Primary Care Provider with a primary behavioral health diagnosis (ICD-9-CM 290.xx - 319.xx) or behavioral health services described in CPT procedure code range 96150 through 96155. CONTRACTOR covered services shall also include medical evaluations provided by a neurologist, as approved by the CONTRACTOR, and/or an emergency room provider, that result in a primary behavioral health diagnosis (ICD-9-CM 290.xx - 319.xx).
Lab & X-Ray Services	As medically necessary.
Newborn Services	As medically necessary including circumcisions performed by a physician.
Hospice Care	As medically necessary. Must be provided by an organization certified pursuant to Medicare Hospice requirements.

Amendment 12 (cont.)

	<p>If a Medicaid hospice patient resides in a nursing facility (NF), the CONTRACTOR must pay an amount equal to at least 95 percent of the prevailing NF room and board rate to the hospice provider.</p>
<p>Dental Services</p>	<p>Preventive, diagnostic and treatment services for enrollees under age 21.</p> <p>Services for enrollees age 21 or older limited to cases of accidental injury to or neoplasms of the oral cavity, life threatening infections that include, but are not limited to, individuals with severely compromised immune systems, organ donor recipients, or individuals with or scheduled to receive a prosthetic heart valve(s), accidental injury to natural teeth including their replacement (limited to the cost of bridgework or the replacement of teeth injured in an accident unless teeth implants are medically necessary) and the removal of impacted wisdom teeth. (The adult dental "accident" must be caused by some external force, like a car accident, not by some normal act of mastication, or grinding of teeth while sleeping, or any other naturally occurring circumstance and must have occurred during a period of TennCare eligibility and within twelve (12) months from the date service is requested.) Orthodontics limited to individuals under 21 except when an orthodontic treatment plan is approved prior to the enrollee attaining 20 1/2 years of age, and treatment is initiated prior to the recipient attaining 21 years of age, or when orthodontic treatment is the result of facial hemiatrophy or congenital birth defects (if enrollee was covered by TennCare at birth).</p> <p>Effective October 1, 2002, the aforementioned covered dental services shall be provided by the Dental Benefits Manager. The provision of transportation to and from said services as well as the medical and anesthesia services related to the dental service that are not provided by a dentist or in a dentist's office shall remain with the CONTRACTOR.</p> <p>Effective August 1, 2005, unless the CONTRACTOR is otherwise notified by TENNCARE, coverage shall be as follows:</p> <p>Medicaid/Standard Eligible, Age 21 and older: Non-covered.</p> <p>Medicaid/Standard Eligible, Under age 21: The CONTRACTOR shall cover Dental preventive, diagnostic and treatment services for enrollees under age 21. Orthodontics limited to individuals under 21 except when an orthodontic treatment plan is approved prior to the enrollee attaining 20 1/2 years of age, and treatment is initiated prior to the recipient attaining 21 years of age.</p> <p>Effective October 1, 2002, the aforementioned covered dental services shall be provided by the Dental Benefits Manager. The provision of transportation to and from said services as well as the medical and anesthesia services related to the dental service that are not provided by a dentist or in a dentist's office shall remain with the CONTRACTOR.</p> <p>(See Section 2-3.1, and 2-3.4)</p>

Amendment 12 (cont.)

<p>Vision Services</p>	<p>Preventive, diagnostic and treatment services (including eyeglasses) for enrollees under age 21. The first pair of cataract glasses or contact lens/lenses following cataract surgery is covered for adults.</p>
<p>Home Health Care</p>	<p>As medically necessary.</p>
<p>Pharmacy Services (obtained directly from an ambulatory retail pharmacy setting, outpatient hospital pharmacy, mail order pharmacy or those administered to a long-term care facility resident (nursing facility))</p>	<p>As medically necessary. Non-covered therapeutic classes as described in Section 2-3.13, DESI, LTE, IRS drugs excluded.</p> <p>TENNCARE is responsible for the provision and payment of pharmacy benefits to individuals who are enrolled in the TennCare Program in the category of TennCare Medicaid/Medicare dual eligible. (However, this does not include pharmaceuticals administered in a doctor's office.)</p> <p>TENNCARE is not responsible for the provision and payment of pharmacy services for TennCare Medicaid/Medicare dual eligibles prior to the date that TENNCARE has notified the CONTRACTOR through the regular electronic eligibility update that these individuals are eligible in the TennCare/Medicare dual eligible category.</p> <p>Effective July 1, 2003, the aforementioned covered pharmacy services shall be provided by the Pharmacy Benefits Manager (PBM) contracted by the TENNCARE Bureau. Pharmacies providing home infusion drugs and biologics only (not including services) shall bill the PBM.</p> <p>Diabetic monitors and supplies as well as injectable drugs obtained directly from a pharmacy provider shall be included in the covered pharmacy services that will be provided by the TennCare Pharmacy Benefit Manager effective July 1, 2003.</p> <p>The CONTRACTOR shall be responsible for reimbursement of injectable drugs obtained in an office/clinic setting in accordance with benefits described herein and to providers providing both home infusion services and the drugs and biologics. Effective July 1, 2005, the CONTRACTOR shall require that all home infusion claims contain NDC coding and unit information to be paid.</p> <p>Effective August 1, 2005, unless the CONTRACTOR is otherwise notified by TENNCARE, the Benefit Limits for Pharmacy coverage, as provided by the PBM shall be as follows:</p> <p>Non-Institutionalized Mandatory and Optional (other than Medically Needy) Medicaid Adults (Age 21 and older) and Pregnant Medically Needy Adults (Age 21 and older): 5 Prescriptions per Month of which only 2 may be Brand name</p> <p>Institutionalized Medicaid Adults (Age 21 and older): As medically necessary</p> <p>Medically Needy Non-Institutionalized, Non-Pregnant Adults (Age 21 and older): Non-covered.</p>

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	<p>Standard Eligible, Age 21 and older: Non-covered</p> <p>Medicaid/Standard Eligible, Under age 21: As medically necessary</p>
Durable Medical Equipment	<p>As medically necessary.</p> <p>Specified DME services shall be covered/non-covered in accordance with the TennCare rules and regulations.</p>
Medical Supplies	As medically necessary.
Emergency Ambulance Transportation	As medically necessary.
Non-Emergency Ambulance Transportation	As medically necessary.
Non-Emergency Transportation	<p>As necessary for enrollees lacking accessible transportation for covered services.</p> <p>The travel to access primary care and dental services must meet the requirements of the waiver terms and conditions. The availability of specialty services as related to travel distance should meet the usual and customary standards for the community. However, in the event the MCO is unable to negotiate such an arrangement for an enrollee, transportation must be provided regardless of whether or not the enrollee has access to transportation. If the enrollee is a child, transportation must be provided for the child and an accompanying adult. However, transportation for a child shall not be denied pursuant to any policy which poses a blanket restriction due to enrollees age or lack of parental accompaniment. Any decision to deny transportation of a child due to an enrollee's age or lack of parental accompaniment must be made on a case-by-case basis and must be based on the individual facts surrounding the request. As with any denial, all notices and actions must be in accordance with the appeal process.</p> <p>At such time that TENNCARE carves out the CONTRACTOR's responsibility to provide Dental Services, the provision of transportation to and from said services shall remain with the CONTRACTOR.</p>
Community Health Clinic Services	As medically necessary.
Renal Dialysis Services	As medically necessary.
EPSDT Services for enrollees under age 21 in accordance with federal regulations as	Screening, interperiodic screening, diagnostic and follow-up treatment services as medically necessary in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989 for enrollees under 21.

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<p>described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.</p>	<p>Except for Dental services, Screens shall be in accordance with the periodicity schedule set forth in the latest "American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care" and all components of the screens must be consistent with the latest "American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care". Dental screens shall be in accordance with the latest periodicity schedule set forth by the American Academy of Pediatric Dentistry and all components of the screens must be consistent with the latest recommendations by the American Academy of Pediatric Dentistry. Tools to be used for screenings shall be consistent with the EPSDT Screening Guidelines as described in Attachment VIII of the Contract. EPSDT services also include maintenance services which are services which have been determined to be effective in preventing or mitigating the worsening of an individual's conditions or preventing the development of additional health problems.</p>
<p>Rehabilitation Services</p>	<p>As medically necessary when determined cost effective by the MCO.</p> <p>All medically necessary services shall be provided to enrollees under 21 years of age in accordance with EPSDT requirements including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.</p>
<p>Chiropractic Services</p>	<p>When determined cost effective by the MCO.</p>
<p>Private Duty Nursing</p>	<p>As medically necessary and when prescribed by an attending physician for treatment and services rendered by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), who is not an immediate relative.</p>
<p>Speech Therapy</p>	<p>As medically necessary, by a Licensed Speech Therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic or personality disorder. All medically necessary services shall be provided to enrollees under 21 years of age in accordance with EPSDT requirements including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.</p>
<p>Sitter</p>	<p>As medically necessary, a sitter who is not a relative may be used where an enrollee is confined to a hospital as a bed patient and certification is made by a network physician that R.N. or L.P.N. is needed and neither is available.</p> <p>Effective August 1, 2005, Non-Covered, unless the CONTRACTOR is otherwise notified by TENNCARE.</p>
<p>Convalescent Care</p>	<p>Upon receipt of proof that a Covered Person has incurred Medically Necessary expenses related to convalescent care, the Plan shall pay for up to and including the one-hundredth (100th) day of confinement during any calendar year for convalescent facility(ies) room, board and general nursing care, provided: (1) a Physician recommends confinement for convalescence; (2) the enrollee is under the</p>

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	<p>continuous care of a Physician during the entire period of confinement; and (3) the confinement is required for other than custodial care.</p> <p>Effective August 1, 2005, Non-Covered, unless the CONTRACTOR is otherwise notified by TENNCARE.</p>
Organ and Tissue Transplants and Donor Organ Procurement	As medically necessary for a covered organ and tissue transplant.
Reconstructive Breast Surgery	<p>In accordance with TCA 56-7-2507, which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy as well as any surgical procedure on the non-diseased breast deemed necessary to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast to establish symmetry with the diseased breast will only be covered if the surgical procedure performed on a non-diseased breast occurs within five (5) years of the date the reconstructive breast surgery was performed on a diseased breast.</p> <p>Note: Applicable CPT procedure codes regarding the revision of undiseased breast following mastopexy or mastectomy for breast cancer, for the purpose of restoring symmetry, shall be the CPT procedures codes in the following range: 19316 – 19396.</p>

2-3.1.2 TennCare Benefits, effective July 1, 2006:

Should TENNCARE eliminate a specified population from eligibility in the TennCare Program, Services/Benefits listed below shall no longer be applicable for said population.

TENNCARE shall provide the CONTRACTOR with a shortlist of services that shall be excluded from benefit limits that are described below.

If at anytime TENNCARE determines that certain benefit limits shall not be imposed or shall be implemented on a different effective date, TENNCARE shall notify the CONTRACTOR by written notice. To the extent that there are substantive changes in the benefit design from what is described below, the CONTRACTOR shall have a reasonable time frame to implement said substantive changes.

For purposes of this Section, "Institutionalized Medicaid" shall be defined as individuals who are receiving (as described in TennCare/Medicaid rules and regulations) long term care institutional services in a nursing home, an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or waiver covered services provided through the Home and Community Based Services (HCBS) waiver for these institutional services.

SERVICE	BENEFIT
Inpatient Hospital Services	Non-Institutionalized Medicaid Eligible, Age 21 and older: Limited to 20 days per calendar year.

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	<p>Institutionalized Medicaid: As medically necessary.</p> <p>Standard Eligible, Age 21 and older: Limited to 20 days per calendar year.</p> <p>Medicaid/Standard Eligible, Under age 21: As medically necessary, rehabilitation hospital facility services are covered under EPSDT for Medicaid eligible children and as medically necessary for Standard eligible children.</p> <p>NOTE: Age 21 and older: Inpatient rehabilitation hospital facility services may be covered when determined to be a cost-effective alternative by the MCO.</p>
<p>Outpatient Hospital Services</p>	<p>Non-Institutionalized Medicaid Eligible, Age 21 and older: Limited to 8 visits per calendar year.</p> <p>Institutionalized Medicaid: As medically necessary.</p> <p>Standard Eligible, Age 21 and older: Limited to 8 visits per calendar year.</p> <p>Medicaid/Standard Eligible, Under age 21: As medically necessary.</p>
<p>Physician Inpatient Services</p>	<p>Non-Institutionalized Medicaid/Standard Eligible, Age 21 and older: Limited to 20 days per calendar year.</p> <p>Institutionalized Medicaid: As medically necessary.</p> <p>Medicaid/Standard Eligible, Under age 21: As medically necessary.</p>
<p>Physician Outpatient Services/Community Health Clinic Services/Other Clinic Services</p>	<p>Non-Institutionalized Medicaid/Standard Eligible, Age 21 and older: Limited to 12 visits per calendar year.</p> <p>Institutionalized Medicaid: As medically necessary.</p> <p>Medicaid/Standard Eligible, Under age 21: As medically necessary.</p> <p>NOTE: This shall include services provided by a Primary Care Provider with a primary behavioral health diagnosis (ICD-9-CM 290.xx - 319.xx) or behavioral health services described in CPT procedure code range 96150 through 96155.</p> <p>CONTRACTOR covered services shall also include medical evaluations provided by a neurologist, as approved by the CONTRACTOR, and/or an emergency room provider, that result in a primary behavioral health diagnosis (ICD-9-CM 290.xx - 319.xx).</p>
<p>EPSDT</p>	<p>Medicaid/Standard Eligibles, Age 21 and older: not covered.</p>

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<p>Services for enrollees under age 21 in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.</p>	<p>Medicaid/Standard Eligibles, Under age 21: Covered as medically necessary, except that the screenings do not have to be medically necessary. Children may also receive screenings in-between regular checkups if a parent or caregiver believes there is a problem.</p> <p>Screening, interperiodic screening, diagnostic and follow-up treatment services as medically necessary in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989 for enrollees under 21. Except for Dental services, Screens shall be in accordance with the periodicity schedule set forth in the latest "American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care" and all components of the screens must be consistent with the latest "American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care". Dental screens shall be in accordance with the latest periodicity schedule set forth by the American Academy of Pediatric Dentistry and all components of the screens must be consistent with the latest recommendations by the American Academy of Pediatric Dentistry. Tools to be used for screenings shall be consistent with the EPSDT Screening Guidelines as described in Attachment VIII of the Contract. EPSDT services also include maintenance services which are services which have been determined to be effective in preventing or mitigating the worsening of an individual's conditions or preventing the development of additional health problems.</p>
<p>Preventive Care Services</p>	<p>As described in Section 2-3.3.</p>
<p>Lab and X-ray Services</p>	<p>Non-Institutionalized Medicaid/Standard Eligible, Age 21 and older: Limited to 10 visits per calendar year.</p> <p>Institutionalized Medicaid: As medically necessary.</p> <p>Medicaid/Standard Eligible, Under age 21: As medically necessary.</p>
<p>Hospice Care</p>	<p>As medically necessary. Must be provided by a Medicare-certified hospice.</p> <p>If a Medicaid hospice patient resides in a nursing facility (NF), the CONTRACTOR must pay an amount equal to at least 95 percent of the prevailing NF room and board rate to the hospice provider.</p>
<p>Dental Services</p>	<p>Dental Services shall be provided by the Dental Benefits Manager.</p> <p>Medicaid/Standard Eligible, Age 21 and older: Non-covered.</p> <p>Medicaid/Standard Eligible, Under age 21: The CONTRACTOR shall cover Dental preventive, diagnostic and treatment services for enrollees under age 21. Orthodontics limited to individuals under 21</p>

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	<p>except when an orthodontic treatment plan is approved prior to the enrollee attaining 20 1/2 years of age, and treatment is initiated prior to the recipient attaining 21 years of age.</p> <p>Effective October 1, 2002, the aforementioned covered dental services shall be provided by the Dental Benefits Manager. The provision of transportation to and from said services as well as the medical and anesthesia services related to the dental service that are not provided by a dentist or in a dentist's office shall remain with the CONTRACTOR.</p> <p>(See Section 2-3.1, and 2-3.4)</p>
<p>Vision Services</p>	<p>Medicaid/Standard Eligible, Age 21 and older: Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of refractive state), will be covered but shall be subject to the service limitations as described elsewhere in this Contract. Routine periodic assessment, evaluation, or screening of normal eyes and examinations for the purpose of prescribing fitting or changing eyeglass and/or contact lenses will not be covered. One pair of cataract glasses or lenses is covered for adults following cataract surgery.</p> <p>Medicaid/Standard Eligible, Under age 21: Preventive, diagnostic, and treatments services (including eyeglasses), are covered as medically necessary.</p>
<p>Home Health Care</p>	<p>As medically necessary.</p>
<p>Pharmacy Services</p>	<p>Pharmacy services shall be provided by the Pharmacy Benefits Manager (PBM), unless otherwise described below.</p> <p>Non-Institutionalized Mandatory and Optional (other than Medically Needy) Medicaid Adults (Age 21 and older) and Medically Needy Adults (Age 21 and older): 5 Prescriptions per Month of which only 2 may be Brand name</p> <p>Institutionalized Medicaid Adults (Age 21 and older): As medically necessary</p> <p>Standard Eligible, Age 21 and older: Non-covered</p> <p>Medicaid/Standard Eligible, Under age 21: As medically necessary</p> <p>NOTE: Certain drugs (known as DESI, LTE, or IRS drugs) are excluded from coverage.</p> <p>Limits on Pharmacy benefits as well as the effective dates thereof are subject to change based on Waiver and/or Court negotiations.</p>

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	<p>Effective July 1, 2003, the aforementioned covered pharmacy services shall be provided by the Pharmacy Benefits Manager (PBM) contracted by the TENNCARE Bureau. Pharmacies providing home infusion drugs and biologics only (not including services) shall bill the PBM.</p> <p>Diabetic monitors and supplies as well as injectable drugs obtained directly from a pharmacy provider shall be included in the covered pharmacy services that will be provided by the TennCare Pharmacy Benefit Manager effective July 1, 2003.</p> <p>CONTRACTOR RESPONSIBILITIES: The CONTRACTOR shall be responsible for reimbursement of injectable drugs obtained in an office/clinic setting in accordance with benefits described herein and to providers providing both home infusion services and the drugs and biologics. Effective July 1, 2005, the CONTRACTOR shall require that all home infusion claims contain NDC coding and unit information to be paid.</p> <p>Services reimbursed by the CONTRACTOR shall not be included in the Pharmacy Benefit Limits as described above.</p>
<p>Durable Medical Equipment</p>	<p>As medically necessary.</p> <p>Specified DME services shall be covered/non-covered in accordance with the TennCare rules and regulations.</p>
<p>Medical Supplies</p>	<p>As medically necessary.</p>
<p>Emergency Air And Ground Ambulance Transportation</p>	<p>As medically necessary.</p>
<p>Non-emergency Transportation (including Non-Emergency Ambulance Transportation)</p>	<p>As necessary to get an enrollee to and from covered services, for enrollees not having access to transportation. MCOs may require advance notice of the need in order to timely arrange transportation.</p> <p>The travel to access primary care and dental services must meet the requirements of the waiver terms and conditions. The availability of specialty services as related to travel distance should meet the usual and customary standards for the community. However, in the event the MCO is unable to negotiate such an arrangement for an enrollee, transportation must be provided regardless of whether or not the enrollee has access to transportation. If the enrollee is a child, transportation must be provided for the child and an accompanying adult. However, transportation for a child shall not be denied pursuant to any policy which poses a blanket restriction due to enrollees age or lack of parental accompaniment. Any decision to deny transportation of a child due to an enrollees age or lack of parental accompaniment must be made on a case-by-case basis and must be based on the individual facts surrounding the request. As with any denial, all notices and actions must be in accordance with</p>

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	<p>the appeal process.</p> <p>The CONTRACTOR shall provide transportation to and from Dental Services.</p>
Renal Dialysis Services	As medically necessary.
Private Duty Nursing	As medically necessary and when prescribed by an attending physician for treatment and services rendered by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), who is not an immediate relative.
Speech Therapy	<p>Medicaid/Standard Eligible, Age 21 and older: Covered as medically necessary by a Licensed Speech Therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic or personality disorder.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with EPSDT requirements.</p>
Occupational Therapy	<p>Medicaid/Standard Eligible, Age 21 and older: Covered as medically necessary when provided by a Licensed Occupational Therapist to restore, improve, or stabilize impaired functions.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with EPSDT requirements.</p>
Physical Therapy	<p>Medicaid/Standard Eligible, Age 21 and older: Covered as medically necessary when provided by a Licensed Physical Therapist to restore, improve, or stabilize impaired functions.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with EPSDT requirements.</p>
Organ and Tissue Transplant And Donor Organ Procurement	<p>Medicaid/Standard Eligible, Age 21 and older: All medically necessary and non-investigational/experimental organ and tissue transplants, as covered by Medicare, are covered. These include, but may not be limited to:</p> <ul style="list-style-type: none"> Bone marrow/Stem cell; Cornea; Heart; Heart/Lung; Kidney; Kidney/Pancreas; Liver; Lung; Pancreas; and Small bowel/Multi-visceral. <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with EPSDT requirements. Experimental or investigational transplants are not covered.</p>

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Reconstructive Breast Surgery	Covered in accordance with TCA 56-7-2507, which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy, as well as surgical procedures on the non-diseased breast to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast to establish symmetry with the diseased breast will only be covered if the surgical procedure performed on a non-diseased breast occurs within five (5) years of the date the reconstructive breast surgery was performed on a diseased breast.
Chiropractic Services	Medicaid/Standard Eligible, Age 21 and older: Not covered. Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with EPSDT requirements.
Sitter	Medicaid/Standard Eligible, Age 21 and older: NON COVERED Medicaid/Standard Eligible, Under age 21: Covered as medically necessary.
Convalescent Care	Medicaid/Standard Eligible, Age 21 and older: NON COVERED Medicaid/Standard Eligible, Under age 21: Covered as medically necessary.

7. Section 2-3.2 shall be deleted and replaced in its entirety so that the amended Section 2-3.2 shall read as follows:

2-3.2. Medical Necessity Determination

The CONTRACTOR shall not impose any service limitations that are more restrictive than those described herein; however, this provision shall not limit the CONTRACTOR's ability to establish procedures for the determination of medical necessity or to use medically appropriate, cost effective alternative services, in accordance with Section 2-3.h, which have been approved by the Centers for Medicare & Medicaid Services. The determination of medical necessity shall be made on a case by case basis. Except for benefit limits as may be described in Section 2-3.a, the CONTRACTOR shall not employ, and shall not permit others acting on their behalf to employ utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each TennCare enrollee and his/her medical history. The CONTRACTOR shall have the ability to place tentative limits on a service; however, such tentative limits placed by the CONTRACTOR shall be exceeded when medically necessary based on a patient's individual characteristics. The CONTRACTOR shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. The CONTRACTOR may deny services that are non-covered except as otherwise required by EPSDT or unless otherwise directed to provide by TENNCARE and/or an administrative law judge. Any procedures used to determine medical necessity shall be consistent with the definition of medical necessity as described in this Contract.

All medically necessary services shall be covered for enrollees under 21 years of age in accordance with EPSDT requirements, including federal regulations as described in 42 CFR Part 441, Subpart B, and the

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Omnibus Budget Reconciliation Act of 1989. Effective upon receipt of written notification from TENNCARE, the CONTRACTOR is not required to provide services in accordance with EPSDT requirements to TennCare Standard enrollees under the age of 21.

8. Section 2-3.12 shall be deleted and replaced in its entirety so that the amended Section 2-3.12 shall read as follows:

2-3.12. Coverage of Organ and Tissue Transplants

The CONTRACTOR shall cover non-investigational/experimental organ and tissue transplants, as covered by Medicare, when medically necessary and consistent with the accepted mode of treatment for which the transplant procedure is performed. Besides the minimally required transplants, the CONTRACTOR may cover other transplants that are not considered investigational or experimental by the National Institutes of Health, if approved by TENNCARE. For purposes of this Section, investigational or experimental shall mean those transplants and/or procedures which are not considered medically necessary and which have not been approved by the Centers for Medicare and Medicaid Services and published in the Federal Register. Questions as to whether a particular transplant and/or procedure is to be covered shall be directed to the Chief Medical Officer, Bureau of TENNCARE.

Exceptions to the above list of transplants must be made for other non-investigational/non-experimental transplants if the transplant and/or procedure is found to be medically necessary, performed within the accepted mode of treatment for which it is intended, and is found to be cost effective as determined by the CONTRACTOR.

The CONTRACTOR shall establish its own administrative procedures regarding the necessity of prior approval before a transplant procedure is performed. The CONTRACTOR shall also establish its own administrative procedures regarding the coverage of transplant procedures performed outside the CONTRACTOR's service area as well as transplant procedures performed out-of-state. Until January 1, 2003, the CONTRACTOR shall utilize its transplant policies and procedures that were in effect as of April 16, 2002, unless otherwise authorized by TENNCARE.

Section 1862 of the Social Security Act requires Medicare beneficiaries to have transplants performed in Medicare certified centers. In accordance with this policy, the CONTRACTOR and Medicare/Medicaid dually eligible enrollees shall be required to adhere to these requirements.

9. Section 2-3.16.4(b) and (d) shall be deleted and replaced in their entirety so that the amended Sections 2-3.16.4(b) and (d) shall read as follows:

- (b) Reporting, including but not limited to, Quarterly EPSDT reports; and
- (d) The "EPSDT Screening Guidelines" as described herein this Section 2-3.16 and Attachments VIII of this Contract.

10. Section 2-4.5 shall be deleted in its entirety and replaced in its entirety so that the amended Section 2-4.5 shall read as follows:

2-4.5. Abusive Utilizers of Pharmacy Services

The CONTRACTOR shall send information to TENNCARE and the Office of Inspector General regarding lock-in candidates. Enrollees who disagree with such restrictions may appeal to TENNCARE pursuant to the medically necessary provisions of the TennCare hearing rules.

The TENNCARE PBM shall provide a monthly report to the CONTRACTOR listing all members identified for pharmacy lock-in. The CONTRACTOR shall use the report to identify enrollees requiring

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case management services as well as to notify the member's PCP and other appropriate health care providers.

11. The last paragraph of Section 2-4.7.1 shall be deleted and replaced in its entirety so that the amended Section 2-4.7.1 shall read as follows:

2-4.7.1. Emergency Medical Services obtained from Out of Plan Providers

The CONTRACTOR's plan shall include provisions governing utilization of and payment by the CONTRACTOR for emergency medical services received by an enrollee from non-contract providers, regardless of whether such emergency services are rendered within or outside the community service area covered by the plan. Coverage of emergency medical services shall not be subject to prior authorization by the CONTRACTOR and shall be consistent with federal requirements regarding post-stabilization services, including but not limited to, 42 CFR Section 438.114(c)(1)(ii)(A). Utilization of and payments to non-contract providers may, at the CONTRACTOR's option, be limited to the treatment of emergency medical conditions, including post-stabilization care that includes medically necessary services rendered to the enrollee until such time as he/she can be safely transported to an appropriate contract service location. Payment amounts shall be consistent with the pricing policies developed by the CONTRACTOR and in accordance with TENNCARE requirements, including TENNCARE rules and regulations for emergency out-of-plan services. Payment by the CONTRACTOR for properly documented claims for emergency medical services rendered by a non-contract provider shall be made within thirty (30) calendar days of receipt of a clean claim by the CONTRACTOR.

The CONTRACTOR must review and approve or disapprove claims for emergency medical services based on the definition of emergency medical services specified in Section 1-3 of this Contract. If the CONTRACTOR determines that a claim requesting payment of emergency medical services does not meet the definition as specified in Section 1-3 and subsequently denies the claim, the CONTRACTOR shall notify the provider of the denial. This notification shall include information to the provider regarding the CONTRACTOR's process and timeframes for reconsideration and subsequent steps regarding an informal review by TENNCARE. In the event a provider disagrees with the CONTRACTOR's decision to disapprove a claim for emergency medical services, the provider may pursue the independent review process for disputed claims as provided by T.C.A., Section 56-32-226, including but not limited to MCO reconsideration.

12. Section 2-4.7. shall be amended by adding a new Section 2-4.7.6 which shall read as follows:

2-4.7.6. Credentialing of Non-Contract Providers

Credentialing Standards must apply to all licensed independent practitioners or groups of practitioners who have an independent relationship with the CONTRACTOR. An independent relationship is not synonymous with an independent contract.

13. Section 2-4.11 shall be deleted and replaced in its entirety so that the amended Section 2-4.11 shall read as follows:

2-4.11. Cost Sharing for Services

The CONTRACTOR and all providers and subcontractors shall not require any cost sharing responsibilities for TennCare covered services except to the extent that cost sharing responsibilities are required for those services by TENNCARE in accordance with TennCare rules and regulations, including but not limited to, holding enrollees liable for debt due to insolvency of the MCO or non-payment by the State to the MCO. Further, the CONTRACTOR and all providers and subcontractors may not charge enrollees for missed appointments.

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TennCare cost sharing responsibilities shall apply to services other than the preventive services described in Section 2-3.3 of this Contract. The current cost share schedule to be used in determining applicable cost sharing responsibilities is included in this Contract as Attachment XI.

Effective for services provided on or after January 1, 2001, the CONTRACTOR shall be expressly prohibited from waiving or using any alternative TennCare cost sharing schedules, unless required by TENNCARE, regardless of whether or not the CONTRACTOR has been previously approved by TENNCARE to do so.

If, and at such time that TENNCARE amends any TennCare rules or regulations, including but not limited to the TennCare cost sharing rules and regulations, the rules shall automatically be incorporated into this Contract and become binding on the MCO and the MCO's providers.

Providers or collection agencies acting on the provider's behalf may not bill enrollees for amounts other than applicable TennCare cost sharing responsibilities for TennCare covered services, including but not limited to, services that the State or the MCO has not paid for except as permitted by TennCare rules and regulations 1200-13-13-.08, 1200-13-14-.08 and as described below. Providers may seek payment from an enrollee only in the following situations:

1. If the services are not covered by the TennCare program and, prior to providing the services, the provider informed the enrollee that the services were not covered. The provider is required to inform the enrollee of the non-covered service and have the enrollee acknowledge the information. If the enrollee still requests the service, the provider shall obtain such acknowledgment in writing prior to rendering the service. Regardless of any understanding worked out between the provider and the enrollee about private payment, once the provider bills an MCO for the service that has been provided, the prior arrangement with the enrollee becomes null and void without regard to any prior arrangement worked out with the enrollee; or
2. If the enrollee's TennCare eligibility is pending at the time services are provided and if the provider informs the person they will not accept TennCare assignment whether or not eligibility is established retroactively. Regardless of any understanding worked out between the provider and the enrollee about private payment, once the provider bills an MCO for the service the prior arrangement with the enrollee becomes null and void without regard to any prior arrangement worked out with the enrollee; or
3. If the enrollee's TennCare eligibility is pending at the time services are provided, however, all monies collected, except applicable TennCare cost share amounts must be refunded when a claim is submitted to an MCO if the provider agreed to accept TennCare assignment once retroactive TennCare eligibility was established. (The monies collected shall be refunded as soon as a claim is submitted and shall not be held conditionally upon payment of the claim); or
4. If the services are not covered because they are in excess of an enrollee's benefit limit and one of the following circumstances applies:
 - (a) The provider determines effective on the date of service that the enrollee has reached his/her benefit limit for the particular service being requested and, prior to providing the service, informs the enrollee that the service is not covered and the service will not be paid for by TennCare. The source of the provider's information must be a database listed on the TennCare website as approved by TennCare on the date of the provider's inquiry;
 - (b) The provider has information in his/her own records to support the fact that the enrollee has reached his/her benefit limit for the particular service being requested, and, prior to providing the service, informs the enrollee that the service is not covered and will not be paid for by TennCare. This information may include:

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- (i) A previous written denial of a claim on the basis that the service was in excess of the enrollee's benefit limit for a service within the same benefit category as the service being requested, if the time period applicable to that benefit limit is still in effect;
 - (ii) That the provider had previously examined the database referenced in part 1. above and determined that the enrollee had reached his/her benefit limit for the particular service being requested, if the time period applicable to that benefit limit is still in effect;
 - (iii) That the provider had personally provided services to the enrollee in excess of his/her benefit limit within the same benefit category as the service being requested, if the time period applicable to that benefit limit is still in effect.
- (c) The provider submits a claim for service to the appropriate managed care contractor (MCC) and receives a written denial of that claim on the basis that the service exceeds the enrollee's benefit limit. Then and thereafter, within the remainder of the period applicable to that benefit limit, the provider may continue to bill the enrollee for services within that same exhausted benefit category without having to submit, for repeated MCC denial, claims for those subsequent services.
- (d) The provider had previously taken the steps in parts 1., 2., or 3. above and determined that the enrollee had reached his/her benefit limit for the particular service being requested, if the time period applicable to that benefit limit is still in effect, and informs the enrollee, prior to providing the service, that the service is not covered and will not be paid for by TennCare.

The CONTRACTOR shall require, as a condition of payment, that the service provider accept the amount paid by the CONTRACTOR or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payor) plus any applicable amount of TennCare cost sharing responsibilities due from the enrollee as payment in full for the service. Should a provider, or a collection agency acting on the provider's behalf, bill an enrollee for amounts other than the applicable amount of TennCare cost sharing responsibilities due from the enrollee, once a CONTRACTOR becomes aware the CONTRACTOR shall notify the provider and demand that the provider and/or collection agency cease such action against the enrollee immediately. After notification by the CONTRACTOR, if a provider continues to bill an enrollee, the CONTRACTOR shall refer the provider to the TBI.

14. Section 2-5 shall be deleted and replaced in its entirety so that the amended Section 2-5 shall read as follows:

2-5. Services Not Covered

The CONTRACTOR shall not pay for non-covered services as described in the TennCare Rules and Regulations at 1200-13-13-.10 and 1200-13-14.10. This includes, but is not limited to; medical services for individuals committed to penal institutions, whether local, state or federal; medical services performed outside the United States; any covered service that is not medically necessary. Further the CONTRACTOR is not obligated to pay for non-emergency services obtained out of plan.

15. Section 2-6.2.c.1, 2 and 3 shall be deleted and replaced in its entirety so that the amended Section 2-6.2.c.1, 2 and 3 shall read as follows:

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1. Member Handbooks. The CONTRACTOR shall develop a member handbook and update it periodically based on a template provided by TENNCARE. Member handbooks must be distributed to enrollees within thirty (30) days of receipt of notice of enrollment in an MCO plan or prior to enrollee's beginning effective date as described in Section 4-1.2 and annually thereafter. In situations where there is more than one enrollee in a TennCare case, it shall be acceptable for the CONTRACTOR to mail one (1) member handbook to each address listed for the enrollee's TennCare case number when there is more than one (1) new enrollee assigned to the same case number at the time of enrollment and when subsequent new or updated member handbooks are mailed to enrollees. Should a single individual be enrolled and be added into an existing case, a member handbook new or updated must be mailed to that individual regardless of whether or not a member handbook has been previously mailed to enrollees in the existing case. Upon notice by TENNCARE of material changes, the CONTRACTOR shall make the appropriate revisions to maintain and redistribute the member handbooks immediately. The CONTRACTOR shall, if determined by TENNCARE, maintain and provide two (2) separate versions of the CONTRACTOR's TennCare Member Handbook for the specific population being served for the purpose of describing Medicaid Benefits to the Medicaid population and Standard Benefits to the Standard population. A member handbook must also be distributed to all contracted providers upon initial credentialing and annually thereafter and as handbooks are updated. For purposes of providing member handbooks to providers, it shall be acceptable to provide handbooks in electronic format, including but not limited to CD or access via a web link. All revisions must be approved by TENNCARE prior to dissemination. Each member handbook shall, at a minimum, be in accordance with the following guidelines:
 - (a) Must be in accordance with all applicable requirements as described in Section 2-6 of this Contract;
 - (b) Shall include a table of contents;
 - (c) Shall include an explanation on how members will be notified of member specific information such as effective date of enrollment;
 - (d) Shall include a description of services provided including limitations, exclusions, and out-of-plan use;
 - (e) Shall include a description of TennCare cost share responsibilities for enrollees including an explanation that providers and/or the MCO may utilize whatever legal actions that are available to collect these amounts. Further, the information shall indicate that the enrollee may not be billed for covered services except for the amounts of the specified TennCare cost share responsibilities and of their right to appeal in the event that they are billed;
 - (f) Shall include information about preventive services for adults and children, including EPSDT for Medicaid eligibles to include a listing of preventive services and notice that preventive services are at no cost and without cost share responsibilities;
 - (g) Shall include procedures for obtaining required services, including procedures for obtaining referrals to specialists as well as procedures for obtaining referrals to providers outside of the plan. The handbook should advise members that if they need a service that is not available within the plan, they will be referred to a provider outside of the plan and any co-payment requirements would be the same as if this provider were in the plan;
 - (h) Shall include an explanation of emergency services and procedures on how to obtain emergency services both in and out of the CONTRACTOR's service area, including but not limited to: an explanation of post stabilization, the use of 911, locations of emergency settings and locations for post-stabilization services;

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- (i) Shall include information on how to access the primary care provider on a 24-hour basis. The handbook may encourage members to contact this 24-hour service when they have questions as to whether they should go to the emergency room;
- (j) Shall include notice to the enrollee of the right to file a complaint as is provided for by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, the Omnibus Budget Reconciliation Act of 1981 (P.E.. 97-35) and a complaint form on which to do so;
- (k) Shall include appeal procedures as described in Section 2-8 of this Contract;
- (l) Shall include notice to the enrollee that in addition to the enrollee's right to file an appeal for actions taken by the CONTRACTOR, the enrollee shall have the right to request reassessment of eligibility related decisions directly to TENNCARE;
- (m) Shall include written policies on member rights and responsibilities, pursuant to 42 CFR 438.100(a)(1) and NCQA's Standards and Guidelines for the Accreditation of MCOs;
- (n) Shall include written information concerning advance directives as described in the Code of Federal Regulations, 42 CFR 489 Subpart I and in accordance with 42 CFR 422.128;
- (o) Shall include notice to the enrollee that enrollment in the CONTRACTOR's plan invalidates any prior authorization for services granted by another plan but not utilized by the enrollee prior to the enrollee's enrollment into the CONTRACTOR's plan and notice of continuation of care when entering the CONTRACTOR's plan as described in Section 2-7.1;
- (p) Shall include notice to the enrollee that it is the member's responsibility to notify the CONTRACTOR and the TENNCARE agency each and every time the member moves to a new address;
- (q) Shall include notice to the enrollee that a new enrollee may request to change MCO plans at anytime during the forty-five (45) day period immediately following their initial enrollment in a MCO plan, subject to the capacity of the selected MCO to accept additional enrollees and any restrictions limiting enrollment levels established by TENNCARE. This process will require the enrollee to notify the State in a form which will be prescribed by the State;
- (r) Shall include notice to the enrollee that the enrollee may change plans during their annual recertification and at the next choice period as described in Section 4 of this Contract and shall have a forty-five (45) day period immediately following the enrollment, as requested during said choice period, in a new plan to request to change plans, subject to the capacity of the selected MCO to accept additional enrollees and any restrictions limiting enrollment levels established by TENNCARE;
- (s) Shall include notice to the enrollee of their right to disenroll from the TennCare program at any time with instructions to contact TENNCARE for disenrollment forms and additional information on disenrollment;
- (t) Shall include the toll free telephone number for TENNCARE with a statement that the enrollee may contact the plan or TENNCARE regarding questions about TennCare. The TennCare hotline number is ;
- (u) Shall include information on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free;

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- (v) Shall include information educating enrollees of their rights and necessary steps to amend their data in accordance with HIPAA regulations;
- (w) Shall include directions in order to obtain information that shall be made available upon request regarding the "structure and operation of the MCO" and "physician incentive plans";
- (x) Shall include right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;
- (y) Shall be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation; and
- (z) Shall include any additional information required in accordance with NCQA's Standards and Guidelines for the Accreditation of MCOs.

Once templates are provided to the CONTRACTOR, the CONTRACTOR shall add MCO specific information as indicated in the template, prepare a mock copy and submit to TENNCARE for approval. If no changes are made to items 2-6.2.c.1(a) through (x), the CONTRACTOR shall be deemed TennCare compliant with the minimum requirements. At such time that TENNCARE provides the CONTRACTOR with edits or revisions to the member handbook, the CONTRACTOR shall agree to utilize the format and make appropriate additions and/or revisions as required by TENNCARE.

In addition to the prior approval requirement regarding dissemination of materials to enrollees, the CONTRACTOR shall also submit to TENNCARE, five (5) final printed originals, unless otherwise specified by TENNCARE.

2. Quarterly Newsletter. The CONTRACTOR shall, at a minimum, distribute on a quarterly basis a newsletter to all enrollees which is intended to educate the enrollee to the managed care system, proper utilization of services, etc., and encourage utilization of preventive care services. The CONTRACTOR shall include the following information in each newsletter:
- (a) specific articles or other specific information as described when requested by TENNCARE. Such requests by TENNCARE shall be limited to two hundred (200) words and shall be reasonable including sufficient notification of information to be included; and
 - (b) the procedure on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free;
 - (c) a notice to enrollees of the right to file a complaint, as is provided for by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, the Omnibus Budget Reconciliation Act of 1981 (P.E. 97-35), and a Contractor phone number for doing so. The notice shall be in English and Spanish;
 - (d) for TennCare enrollees, EPSDT information, including but not limited to, encouragement to obtain screenings and other preventive care services; and
 - (e) the following information to report fraud: "To report fraud or abuse to OIG: You can call free 1-800-433-3982 **OR** Go online at www.state.tn.us/tenncare and click on "Report Fraud."

To report provider fraud or patient abuse to MFCU, call free 1-800-433-5454."

Not more than one hundred twenty (120) calendar days shall elapse between dissemination of this information. In order to satisfy the requirement to distribute the quarterly newsletter to all enrollees, it

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shall be acceptable to mail one (1) quarterly newsletter to each address associated with the enrollee's TennCare case number. In addition to the prior authorization requirement regarding dissemination of materials to enrollees, the CONTRACTOR shall also submit to TENNCARE, five (5) final printed originals, unless otherwise specified by TENNCARE, of the newsletter and the date that the information was mailed to enrollees along with an invoice or other type of documentation to indicate the date and volume of the quarterly newsletter mailing.

3. Identification Card. Each enrollee shall be provided an identification card, which identifies the enrollee as a participant in the TennCare Program within thirty (30) calendar days of notification of enrollment into the CONTRACTOR's plan or prior to enrollee's beginning effective date. The identification card must comply with all state and federal requirements. Once the identification card has been approved by TENNCARE the CONTRACTOR shall submit five (5) printed sample cards of the final product, unless otherwise specified by TENNCARE, to the TennCare Marketing Coordinator within thirty (30) working days from the print date. Photo copies may not be submitted as a final product. Prior to modifying an approved identification card the CONTRACTOR shall submit for approval by TENNCARE a detailed description of the proposed modification. The identification card may be issued by the CONTRACTOR, subject to prior approval of the format and content by TENNCARE, or the identification card may be issued by TENNCARE in a format and content mutually agreed upon by the CONTRACTOR and TENNCARE. Regardless of whether the identification card is issued by the CONTRACTOR or TENNCARE, all expenses associated with production and mailing of the identification card shall be the responsibility of the CONTRACTOR.

16. Section 2-6.7.d shall be deleted and replaced in its entirety so that the amended Section 2-6.7.d shall read as follows:

d. Application of sanctions and/or liquidated damages as provided in Section 6-8 of this Contract.

17. Section 2-7.1 shall be amended by adding a new part e, deleting and replacing the existing part e with a new part f, adding a new part g and renumbering the existing parts so that the new 2-7.1.e, f and g shall read as follows:

- e. Excessive and/or Inappropriate Emergency Department (ED) Utilization

The CONTRACTOR shall utilize the following guidelines in identifying and managing care for enrollees who are determined to have excessive and/or inappropriate ED utilization.

- (1) Review ED utilization data, at a minimum, every six (6) months (in January and June) to identify enrollees with utilization exceeding a threshold defined by TENNCARE in the preceding six (6) month period. In January, review ED utilization during the preceding April through September. In July review ED utilization during the preceding October through March.
- (2) Enroll in active case management -- (Enrollees who exceed a specified number, to be defined by TENNCARE, of ED visits in the previous six (6) month period)
- (3) Make contact with enrollee and primary care provider
- (4) Review encounter data
- (5) Assess most likely cause of problem (e.g., drug seeking behavior, primary care/access problem, poorly controlled disease state, etc.)
- (6) Develop a case management plan based on results of the assessment. Sample plans based on potential assessment results follow:
 - (a) Drug seeking behavior
 - i. Interact with TennCare Pharmacy Division regarding possibility of pharmacy lock-in and/or controlled substance prior authorization requirement
 - ii. Contact all providers regarding concern that patient may be abusing prescription medications

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- iii. Make appropriate referrals (e.g., OIG, Pain clinic, Substance abuse treatment program, etc.)
- iv. Consider primary care provider lock-in (i.e. patient must have PCP approval before he/she can access other providers)
- (b) Primary Care /Access Problem
 - i. Change PCP and/or address problem with current PCP
 - ii. Provide enrollee education regarding appropriate use of PCP and ED
 - iii. Provide access to 1-800 24/7 nurse answered line capable of providing advice and/or making appointment with PCP
- (c) Poorly controlled disease
 - i. Enroll in disease management
 - ii. Refer to specialist for management – advise PCP
 - iii. Provide access to 1-800 24/7 nurse answered line capable of providing advice and/or making appointment with PCP

f. Disease Management

Each MCO is required to establish and operate (either directly or via a subcontract with an accredited disease management vendor) a minimum of four disease management (DM) programs designed to address maternity care management, comprehensive diabetes management, management of congestive heart failure and management of asthma.

Each DM program must utilize evidence-based best practice guidelines and patient empowerment strategies to support the practitioner-patient relationship and the plan of care. The programs must emphasize prevention of exacerbation and complications as evidenced by decreases in emergency room utilization and inpatient hospitalization and/or improvements in condition-specific health status indicators.

(1) Identifying Eligible Members

The MCO must have a systematic method of identifying and enrolling eligible members in each DM program. Annually, on July 1st, the MCO must report to the Bureau the active participation rate for each of the four DM programs. This report must also include a narrative description of the eligibility criteria and the method used to identify and enroll eligible enrollees. The active participation rate, as defined by NCQA, is the percentage of identified eligible members who have received an intervention divided by the total population who meet the criteria for eligibility in the DM program. The MCO must also identify and report the total number of active enrollees having one or more of the diagnosis codes (ICD-9 Codes) relating to each of the required disease management programs. The MCO must operate each program using an “opt out” methodology, meaning that services will be provided to eligible members unless they specifically ask to be excluded. The Bureau may elect to mandate the eligibility criteria the MCO must use if the program evaluation does not demonstrate the desired effect and/or if the Bureau determines that the criteria in use are overly restrictive.

(2) Interventions Based on Stratification

The MCO must classify eligible members according to disease severity or other clinical or member-provided information and provide disease management interventions of differing intensity based on such stratification. The MCO must maintain a written description of the stratification levels for each of the four DM programs including member criteria and associated interventions and make such description available to the Bureau upon request.

(3) Program Content

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The MCO must adopt clinical practice guidelines that serve as the basis for each DM program. The guidelines must be evidence-based and formally adopted by the QI or other clinical committee. The guidelines must be distributed to practitioners who are likely to use them and must be made available to the Bureau upon request. Upon enrollment in the DM program, the MCO must provide information to the member and practitioner regarding how to use the services and specific information to the practitioner concerning how the program works with the practitioner's patients. MCOs must provide primary care providers with a list of their patients enrolled in each program upon initial enrollment and at least annually thereafter.

Each DM program must be based on a treatment plan that serves as the outline for all of the activities/interventions in the program. At a minimum the activities/interventions associated with the treatment plan must address condition monitoring, patient adherence to the treatment plan, consideration of other co-morbidities, and condition-related lifestyle issues. The Bureau may elect to mandate an intervention strategy the MCO must employ if the program evaluation does not demonstrate the desired effect and/or if the Bureau determines that the interventions are suboptimal.

(4) CONTRACTOR's Program Description

Within ninety (90) days of the execution of this Agreement, the CONTRACTOR shall submit a description of its Disease Management Program including all four (4) components as previously described for TENNCARE approval. The description must include the following:

- (a) Definition of the target population for each program; and
- (b) Written description of the stratification levels for each of the four (4) programs, including member criteria and associated interventions.

(5) Program Evaluation

Annually, on July 1st, the MCO will report to the Bureau regarding the following:

- (a) Performance measured against at least two important aspects of the clinical practice guidelines associated with each DM program;
- (b) The rate of emergency department utilization and inpatient hospitalization for members with diabetes, asthma and congestive heart failure (rate calculations must be shown);
- (c) Neonatal Intensive Care Unit (NICU) days for births associated with members enrolled in the Maternity Management Program;
4. HEDIS measures related to any of the four DM projects;
5. Any other performance measure associated with any of the four DM programs that the MCO has chosen to track;
6. The active participation rates (as defined by NCQA) and the number of individuals participating in each level or stratification of each of the DM programs; and
7. the total number of active enrollees having one or more of the diagnosis codes (ICD-9 Codes) relating to each of the required disease management programs.

(g) Disease Management for Obesity

In addition to the aforementioned disease management requirements, the CONTRACTOR agrees to enter into a provider agreement with a vendor that the State shall designate for implementation of a disease management program for obesity.

18. The renumbered Section 2-7.1.i shall be deleted and replaced in its entirety so that the amended Section 2-7.1.i shall read as follows:

i. Prior Authorization for Covered Services

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1. General Rule

The CONTRACTOR and/or its subcontractors shall have in place, and follow, written policies and procedures for processing requests for initial and continuing authorizations of services and have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and consult with the requesting provider when appropriate. If prior authorization of a service is granted by the CONTRACTOR, subcontractor or an agent, payment for the pre-approved service shall not be denied based on the lack of medical necessity, assuming that the enrollee is eligible on the date of service, unless it is determined that the facts at the time of the denial of payment are significantly different than the circumstances which were described at the time that prior authorization was granted. Prior Authorization shall not be required for emergency services. Prior authorization requests shall be reviewed subject to the guidelines described in TennCare Rules 1200-13-13 and 1200-13-14 which include, but are not limited to, provisions regarding decisions, notices, medical contraindication, and the failure of an MCO to act timely upon a request. The CONTRACTOR must use appropriately licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each level of utilization management (UM) decision making. The CONTRACTOR must have written procedures documenting access to Board Certified Consultants to assist in making medical necessity determinations. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

2. At time of Enrollment

In the event an enrollee entering the MCO's plan is receiving medically necessary TennCare covered services the day before enrollment, the CONTRACTOR shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided within or outside the CONTRACTOR's provider network until such time as the CONTRACTOR can reasonably transfer the enrollee to a service and/or network provider without impeding service delivery that might be harmful to the enrollee's health. If it is medically necessary that care extend beyond thirty (30) days, the CONTRACTOR may require prior authorization for continuation of the services beyond thirty (30) days. Care rendered to a CONTRACTOR's enrollee beyond thirty (30) days that is out-of-plan or out-of-network for which a provider has not sought prior authorization need not be reimbursed.

3. Prenatal Care

In the event an enrollee entering the CONTRACTOR's plan is receiving medically necessary prenatal care services the day before enrollment, the CONTRACTOR shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided within or outside the CONTRACTOR's provider network until such time as the CONTRACTOR can reasonably transfer the enrollee to a service and/or network provider without impeding service delivery that might be harmful to the enrollee's health.

In the event an enrollee entering the CONTRACTOR's plan is in her second or third trimester of pregnancy and is receiving medically necessary prenatal care services the day before enrollment, the CONTRACTOR shall be responsible for providing continued access to the provider (regardless of network affiliation) through the postpartum period.

The CONTRACTOR shall require, as a condition of payment, that the service provider accept the amount paid by the CONTRACTOR or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payor) plus any applicable amount of TennCare cost sharing responsibilities due from the enrollee as payment in full for the service.

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4. Notice of Adverse Action Regarding Prior Authorization Requests

The CONTRACTOR must clearly document and communicate the reasons for each denial in a manner sufficient for the provider and member to understand the denial and decide about appealing the decision. Notice of adverse actions to providers and members regarding prior authorization requests shall be provided within the following guidelines:

- (a) Provider Notice. The CONTRACTOR must notify the requesting provider of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider need not be in writing; however, the CONTRACTOR must make a reviewer available to discuss any denial decisions. Information provided to the provider must include how to contact the reviewer.
- (b) Enrollee Notice. See notice provisions in TennCare Rule 1200-13-13-.11 and 1200-13-14-.11.

5. Appeals related to Prior Authorization/Medical Necessity Denials

The Contractor is responsible for eliciting pertinent medical history information from the treating health care provider(s), as needed, for purposes of making medical necessity determinations. The Contractor shall take action (e.g. sending a provider representative to obtain the information and/or discuss the issue with the provider, imposing financial penalties against the provider, etc.), to address the problem if a treating health care provider is uncooperative in supplying needed information. Documentation of such action will be made available to TENNCARE, upon request. Providers who do not provide requested medical record information for purposes of making a medical necessity determination for a particular medical item or service, shall not be entitled to payment for the provision of such medical item or service.

Upon request by TENNCARE in support of making a decision relative to a medical appeal, the CONTRACTOR must provide TENNCARE with individualized medical record information from the treating health care provider(s). The CONTRACTOR must take whatever action necessary to fulfill this responsibility within the required appeal time lines as specified by TENNCARE and/or applicable regulation, up to and including going to the provider's office to obtain the medical record information. Should a provider fail or refuse to respond to the CONTRACTOR's efforts to obtain medical information, and the appeal is decided in favor of the enrollee, at the CONTRACTOR's discretion or a directive by TENNCARE, the CONTRACTOR shall impose financial penalties against the provider as appropriate.

19. Section 2-8 shall be deleted and replaced in its entirety so that the amended Section 2-8 shall read as follows:

2-8. Complaints and Appeals

The enrollees shall have the right to file appeals regarding adverse actions taken by the CONTRACTOR. For purposes of this requirement, appeal shall mean an enrollee's right to contest verbally or in writing, any adverse action taken by the CONTRACTOR to deny, reduce, terminate, delay or suspend a covered service as well as any other acts or omissions of the CONTRACTOR which impair the quality, timeliness, or availability of such benefits. An appeal may be filed by the enrollee or by a person authorized by the enrollee to do so, including but not limited to, a provider with the enrollee's written consent. Complaint shall mean an enrollee's right to contest any other action taken by the CONTRACTOR or service provider other than those that meet the definition of an adverse action. The CONTRACTOR shall provide readable materials reviewed and approved by TENNCARE, informing enrollees of their complaint and appeal rights. The CONTRACTOR has internal complaint and appeal procedures for both TennCare Medicaid enrollees as well as TennCare Standard enrollees in accordance with TennCare rules and regulations 1200-13-13-.11, 1200-13-14-.11 or any applicable TennCare rules

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and regulations, subsequent amendments, TennCare Waiver, or subsequent Court Orders governing the appeals process.

A portion of the regularly scheduled Quality Improvement meetings, as described in Section 2-9.d., shall be devoted to the review of enrollee complaints and appeals that have been received and resolved. The complaint and appeal procedures shall be governed by the following guidelines which are in accordance with TennCare policy as specified in TennCare rules and regulations and any and all Court Orders.

2-8.1. Appeals

The CONTRACTOR's appeal process shall include, at a minimum, the following:

1. The CONTRACTOR shall have a contact person appointed at each service site. Said person will be knowledgeable of appeal procedures and direct all appeals whether the appeal is verbal or the enrollee chooses to file in writing. Should an enrollee choose to appeal in writing, the enrollee will be instructed to file via mail to the designated P. O. Box for appeals related to the CONTRACTOR;
2. There shall be sufficient support staff (clerical and professional) available to process appeals in accordance with TennCare requirements related to the appeal of Adverse Actions Affecting a TennCare Program Enrollee. Staff shall be knowledgeable about applicable state and federal law and all court orders governing appeal procedures, as they become effective. This shall include, but not be limited to, appointed staff members and phone numbers identified to TENNCARE where appropriate staff may be reached;
3. Staff shall be educated concerning the importance of the procedure and the rights of the enrollee and the timeframes in which action must be taken by the CONTRACTOR regarding the handling and disposition of an appeal;
4. The appropriate individual or body within the plan having decision-making authority as part of the appeal procedure shall be identified;
5. The CONTRACTOR shall have the ability to take telephone appeals and accommodate persons with disabilities during the appeals process. Furthermore, appeal forms shall be available at each service site and by contacting the CONTRACTOR. However, enrollees shall not be required to use an appeal form in order to file an appeal;
6. Upon request, the enrollee shall be provided a TENNCARE approved appeal form(s);
7. All appellants shall have the right to reasonable assistance by the CONTRACTOR during the appeal process;
8. At any point in the appeal process, TENNCARE shall have the authority to remove an enrollee from the CONTRACTOR's plan when it is determined that such removal is in the best interest of the enrollee and TENNCARE;
9. The Contractor shall require providers to display notices of enrollee's right to appeal adverse actions affecting services in public areas of each facility in accordance with TennCare rules and regulations. Contractor shall ensure that providers have correct and adequate supply of public notices.
10. Except for initial reconsideration by an MCO, as permitted under the TennCare rules and regulations, no person who is an employee, agent or representative of an MCO may participate in

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deciding the outcome of a TennCare appeal. No state official may participate in deciding the outcome of a beneficiary's appeal who was directly involved in the initial determination of the action in question. The State will ensure that decision makers on grievances and appeals were not involved in previous levels of review or decision-making and who are health care professionals with clinical expertise in treating the enrollee's condition or disease if any of the following apply:

- a denial appeal based on lack of medical necessity.
- a grievance regarding denial of expedited resolutions of an appeal.
- any grievance or appeal involving clinical issues.

The Contractor shall keep a record of who reviews each reconsideration. The State will monitor compliance with this provision. Further, for purposes of assuring timeliness and appropriateness of the provision of services in accordance with Section 4-8.b.2, an MCO's reconsideration to provide services shall be considered the same as a directive to do so by TENNCARE.

11. TENNCARE and/or the CONTRACTOR shall not prohibit or discourage any individual from testifying on behalf of an enrollee.
12. TENNCARE may develop additional appeal process guidelines or rules, including requirements as to content and timing of notices to enrollees, which shall be followed by the CONTRACTOR, if TENNCARE determines that it is in the best interest of the TennCare Program or if necessary to comply with federal or judicial requirements. However, CONTRACTOR shall not be precluded from challenging any judicial requirements and to the extent judicial requirements that are the basis of such additional guidelines or rules are stayed, reversed or otherwise rendered inapplicable, CONTRACTOR shall not be required to comply with such guidelines or rules during any period of such inapplicability.
13. Provide general and targeted education to providers regarding emergency appeals, including when an emergency appeal is appropriate, and procedures for providing written certification thereof. Further, provide for notice to providers regarding provider responsibility in the appeal process, including but not limited to, the provision of medical records and/or documentation as described in Section 2-7.1.g.5.
14. The CONTRACTOR shall urge providers who feel they cannot order a drug on the TennCare Preferred Drug List (PDL) to seek prior authorization in advance, as well as taking the initiative to seek prior authorization when contacted by an enrollee or pharmacy regarding denial of a pharmacy service due to system edits (i.e., therapeutic duplication, etc.)

If it is determined by TENNCARE that violations regarding the appeal guidelines have occurred by the CONTRACTOR, TENNCARE shall require that the CONTRACTOR submit and follow through with a corrective action plan. Failure to comply with the appeal guidelines issued by TENNCARE, including an acceptable corrective action plan, shall result in the CONTRACTOR being subject to liquidated damages as described in Section 6-8. of this Contract.

20. Section 2-9 shall be deleted and replaced in its entirety and any references thereto shall be updated accordingly. Amended Section 2-9 shall read as follows:

2-9. Administration and Management

2-9.1. General Requirements

The State may review and approve all plan policies developed by the CONTRACTOR related to administration of TennCare Select. On an ongoing basis, should the CONTRACTOR have a question on

Amendment 12 (cont.)

policy determinations, benefits or operating guidelines, the CONTRACTOR shall request a determination in writing. The State shall have 30 days to respond unless specified otherwise. Should TennCare not respond in the required amount of time, the CONTRACTOR shall not be penalized as a result of implementing items awaiting approval. However, failure to respond timely shall not preclude the State from requiring the CONTRACTOR to respond or modify the policy or operating guideline prospectively. The CONTRACTOR shall be afforded at least 60 days to implement the modification.

The CONTRACTOR shall meet with representatives of the State upon request to discuss any problems and/or progress on matters outlined by the State. The CONTRACTOR shall have in attendance its Program Director, and representatives from its organizational units required to respond to topics identified by the State or the CONTRACTOR. The CONTRACTOR may be asked to provide information concerning its efforts on network development, provider training, attempts to locate non-responsive TennCare eligibles and trends in costs and utilization.

2-9.2. Performance Benchmarks

The following performance indicators related to administration and management have been identified for on-going monitoring. The CONTRACTOR's failure to meet these benchmarks or demonstrate improvement toward benchmark levels of performance shall result in the CONTRACTOR being required to implement a corrective action plan as described in Section 2-16.

Performance Indicator	Data Sources	Measure	Target	Benchmark
Volume of Provider Complaints	Monthly Activity Report	# of provider complaints received relative to number of providers (Complaint is defined as an issue a provider presents to the managed care organization, either in written or oral form, which is subject to resolution by the MCO).	0 percent	MCO specific benchmark. 10% reduction over prior year.

Amendment 12 (cont.)

Performance Indicator	Data Sources	Measure	Target	Benchmark
<p>Claims Payment Accuracy and Timeliness</p>	<p>Claims and Encounter Data</p> <p>Note: Self-reported based on internal audit conducted on statistically valid random sample on a quarterly basis.</p> <p>Audit procedures and sample methodology to be submitted to TDCI for review and approval with first quarter's report.</p>	<p>1. Accuracy: Number of claims processed for payment and paid accurately upon initial submission divided by the total number of claims.</p> <p>2. Timeliness of Clean Claims Processing: Number of clean claims processed within thirty (30) calendar days of receipt divided by the total number of clean claims received (for calculation date of receipt counts as day zero).</p> <p>Timeliness of Clean and Unclean Claims Processing: Number of claims processed and, if appropriate, paid within sixty (60) days of receipt divided by the number of all claims processed (for calculation date of receipt counts as day zero)</p> <p>Processing To be measured and reported monthly</p>	<p>100 percent</p>	<p>Accuracy: 97% of claims are processed or paid accurately upon initial submission</p> <p>Timeliness of Clean Claims Processing: 90% of clean claims are paid within 30 days of receipt of these claims.</p> <p>Timeliness of Clean and Unclean Claims Processing: 99.5% of all claims within sixty (60) days of receipt.</p>

Amendment 12 (cont.)

Performance Indicator	Data Sources	Measure	Target	Benchmark
Specialist Provider Network	CONTRACTOR'S credentialing reports	Executed contract is a signed agreement with a provider to participate in the Contractor's network	Same as benchmark	<p>1. <u>Physician Specialists:</u> Executed specialty physician contracts in all areas required by this Agreement for the following nine specialists: cardiology; gastroenterology; neurology; neurosurgery; otolaryngology; ophthalmology; orthopedics; oncology/hematology; and urology.</p> <p>2. <u>Essential Hospital Services:</u> Executed contract with at least one (1) Tertiary Care Center for each essential hospital service</p> <p>3. <u>Center of Excellence for People with AIDs:</u> Executed contract with at least one (1) Center of Excellence for AIDs</p>

Amendment 12 (cont.)

Performance Indicator	Data Sources	Measure	Target	Benchmark
Network Adequacy	<p>1. Monthly Provider listings</p> <p>2. Most recent monthly provider listing and random phone surveys conducted by TENNCARE on a quarterly basis</p>	<p>1. Time and travel distance as measured by GeoAccess</p> <p>2. Network validation</p>	Same as Benchmark	<p>1. Provider network includes sufficient numbers and geographical disbursement of providers in order to satisfy the Terms and Conditions for Access of the TennCare Waiver</p> <p>2. At least 90% of records for participating providers on the most recent monthly provider listing can be used to contact the provider and confirm the provider is participating in the MCO's network</p>
Encounter Data Submissions	TennCare Edit Reports	Error Threshold Exceeded	Same as Benchmark	Less than 2% of file contains errors by submission due date

Amendment 12 (cont.)

Performance Indicator	Data Sources	Measure	Target	Benchmark
EPSDT Screening and Medical Record Documentation	MCO Encounter Data and Medical Chart Audit	The EPSDT screening ratio, calculated in accordance with specifications for the CMS-416 report, multiplied by the percentage of the required seven (7) screening components that are completed as determined through a statistically valid sample of medical records of the MCO's enrollees	Same as Benchmark	Demonstrated active pursuit and completion of activities designed to increase the CONTRACTOR's EPSDT screening ratio and the percentage of screens that are completed and include all seven (7) required screening components
CAHPS Survey Report	Annual Member Satisfaction Survey	A set of standardized surveys that measure patient satisfaction with experience of care	Same as Benchmark	Report of annual CAHPS survey results due by June 15 th . Rating of the Healthplan: CONTRACTOR must meet or exceed Medicaid National average as reported in Quality Compass. 2004 rating was 69.9%.
HEDIS Report	Annual HEDIS measurement as required by NCQA	A set of standardized performance measures designed to allow reliable comparison of the performance of managed health care plans	Same as Benchmark	Report of audited HEDIS data due by June 15 th
Provider Satisfaction Survey Report	Annual Provider Satisfaction Survey	Survey of provider satisfaction with Prior Authorization process	Same as Benchmark	Report due by June 15 th

Amendment 12 (cont.)

Performance Indicator	Data Sources	Measure	Target	Benchmark
NCQA Accreditation Report	NCQA	Final Accreditation Report in its entirety from NCQA's initial survey and annual revised accreditation status	Same as Benchmark	Accreditation

2-9.3. Staff Requirements

The staffing for the plan covered by this Contract must be capable of fulfilling the requirements of this Contract. The minimum staff requirements are as follows:

1. A full-time administrator (project director) specifically identified with overall responsibility for the administration of this Contract. This person shall be at the CONTRACTOR's officer level. Said designee shall be responsible for the coordination and operation of all aspects of the Contract;
2. Sufficient full-time clinical and support staff to conduct daily business in an orderly manner, including such functions as administration, accounting and finance, complying with the requirements related to fraud as set forth in Section 1-5 of this Contract, prior authorizations, medical and disease management, marketing, appeal system resolution, and claims processing and reporting, as determined through management and medical reviews;
3. A physician who is licensed in the State of Tennessee to serve as medical director to oversee and be responsible for the proper provision of covered services to members;
4. A staff qualified, medically trained personnel, consistent with accreditation standards of NCQA, JCAHO or URAC whose primary duties are to assist in evaluating claims for medical necessity;
5. A person who is trained and experienced in information systems, data processing and data reporting as required to provide necessary and timely reports to TENNCARE;
6. The CONTRACTOR shall appoint a staff person as its Non-discrimination Compliance Coordinator to be responsible for compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981 (P.E.. 97-35) on behalf of the CONTRACTOR. The CONTRACTOR does not have to require that compliance with the aforementioned federal and state regulations be the sole function of the designated staff member. However, the CONTRACTOR shall identify the designated compliance staff member to TENNCARE by name. At such time that this function is redirected, the name of the staff member who assumed the duties shall be reported in writing to TENNCARE within ten (10) calendar days of the change;

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7. The CONTRACTOR shall appoint a staff person to be responsible for communicating with TENNCARE regarding member service issues. The CONTRACTOR shall maintain statewide, toll-free phone lines (member services hotline) for the exclusive purpose of enrollee inquiries. These phone lines shall be staffed adequately to respond to enrollee's questions during normal business hours, five (5) days a week. The member service lines shall be adequately staffed and trained to accurately respond to questions regarding the TennCare program, including but not limited to EPSDT. Said information may be made available pursuant to the CONTRACTOR's enrollee newsletter or materials distributed pursuant to Section 2-6 of this Contract. The CONTRACTOR shall adequately staff the member service line to assure that the average wait time for assistance does not exceed 10 minutes;
8. The CONTRACTOR shall appoint a staff person to be responsible for communicating with TENNCARE regarding provider service issues. Further, the CONTRACTOR shall have a provider service line staffed adequately to respond to providers questions during normal business hours, including appropriate and timely responses regarding prior authorization requests as described in Section 2-7.1 of this Contract. The provider service lines shall be adequately staffed and trained to accurately respond to questions regarding the TennCare program, including but not limited to EPSDT. The CONTRACTOR shall adequately staff the provider service line to assure that the average wait time for assistance does not exceed 10 minutes.
9. The CONTRACTOR shall identify in writing key contact persons for Contract Administration, Accounting and Finance, Fraud Detection as set forth in Section 1-5 of this Contract, Prior Authorizations, Marketing, Claims Processing, Information Systems, Non-discrimination Compliance, Member Services, Provider Services, Appeal System Resolution, Medical Management, Disease Management, HEDIS, CAHPS, NCQA Accreditation and EPSDT within thirty (30) days of Contract execution. Any changes in staff persons during the term of this Contract must be made in writing within ten (10) business days.
10. The CONTRACTOR shall appoint Care Coordinators and Claim Coordinators in order to coordinate and resolve issues related to MCO/DBM coordination issues as described in Section 2-3.4 of this Contract. Further, the CONTRACTOR shall appoint a Care Coordination Committee and a Claims Coordination Committee made up of the Care/Claim Coordinators and other staff as appropriate. A list with the names and phone numbers of said representatives shall be provided by the MCO to the DBM and TENNCARE.
11. The CONTRACTOR shall appoint Care Coordinators and Claim Coordinators in order to coordinate and resolve issues related to MCO/BHO coordination issues as described in Section 2-3.5 of this Contract. Further, the CONTRACTOR shall appoint a Care Coordination Committee and a Claims Coordination Committee made up of the Care/Claim Coordinators and other staff as appropriate. A list with the names and phone numbers of said representatives shall be provided by the MCO to the BHO, TENNCARE and TDMHDD.

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12. The CONTRACTOR shall appoint and identify in writing to TENNCARE a responsible contact available after hours for the "on-call" TennCare Solutions staff to contact with service issues, including but not limited to, pharmacy issues.
13. The CONTRACTOR shall appoint specific staff to an internal audit department which shall report directly to the board of directors or other such appropriate level of management. The CONTRACTOR shall submit an annual Audit Plan to TENNCARE. The importance of an internal audit function is to provide an independent review and evaluation of the accuracy of financial recordkeeping, the reliability and integrity of information, the adequacy of internal controls, and compliance with applicable laws, policies, procedures, and regulations. The internal audit function shall be responsible for performing audits to ensure the economical and efficient use of resources by all departments to accomplish the objectives and goals for the operations of the department. Further, the internal audit department(s) shall be responsible for performance of the claims payment accuracy tests as described in Section 2-9 and 2-9.7.1 of this Contract.

The CONTRACTOR's failure to comply with staffing requirements as described in this Contract shall result in the application of intermediate sanctions and liquidated damages as specified in Section 6 of this Contract.

2-9.4. Licensure of Staff

The CONTRACTOR is responsible for assuring that all persons, whether they be employees, agents, subcontractors, providers or anyone acting for or on behalf of the CONTRACTOR, are legally authorized to render service under applicable state law and/or regulations. Failure to adhere to this provision shall result in assessment of \$250 per calendar day for each day that personnel are not licensed as required by applicable state law and/or regulation and TENNCARE may terminate this Agreement for cause as described in Section 6.2 of this Contract.

1. TENNCARE may refuse to approve or may rescind the approval of subcontracts with unlicensed persons;
2. TENNCARE may refer the matter to the appropriate licensing authority for action;
3. TENNCARE may assess liquidated damages as described in Section 6 of this Contract; and
4. TENNCARE may terminate this Contract for cause as described in Section 6.2. of this Contract.

The CONTRACTOR's failure to comply with licensure of staff requirements as described in this Contract shall result in the application of intermediate sanctions and liquidated damages as specified in Section 6 of this Contract.

2-9.5. Employment of Personnel

A managed care organization may not knowingly have a director, officer, partner, or person with beneficial ownership of more than 5% of the entity's equity who has been debarred or suspended by any federal agency. A managed care organization may not have an employment, consulting, or any other agreement with a person that has been debarred or suspended by any federal agency for the provision of

Amendment 12 (cont.)

items or services that are significant and material to the entity's contractual obligation with the State. To the best of its knowledge and belief, the CONTRACTOR certifies by its signature to this Contract that the CONTRACTOR and its principals:

1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal or State department or Contractor;
2. have not within a three (3) year period preceding this Contract been convicted of, or had a civil judgment rendered against them from commission of fraud, or a criminal offence in connection with obtaining attempting to obtain, or performing a public (federal, State, or Local) transaction or grant under a public transaction; violation of federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property;
3. are not presently indicted for or otherwise criminally or civilly charged by a government entity (federal, State, or Local) with commission of any of the offenses detailed in section b. of this certification; and
4. have not within a three (3) year period preceding this Contract had one or more public transactions (federal, State, or Local) terminated for cause or default.

2-9.6. Data that must be Certified

When State payments to an MCO are based on data submitted by the MCO, the State must require certification of the data as provided in 42 CFR 438.606. The data that must be certified include, but are not limited to, enrollment information, encounter data, and other information required by the State and contained in contracts, proposals and related documents. The data must be certified by one of the following: the MCO's Chief Executive Officer, The MCO's Chief Financial Officer, or An individual who has delegated authority to sign for, and who reports directly to the MCO's Chief Executive Officer or Chief Financial Officer. The certification must attest, based on best knowledge, information, and belief, as follows:

1. To the accuracy, completeness and truthfulness of the data.
2. To the accuracy, completeness and truthfulness of the documents specified by the State.
3. The MCO must submit the certification concurrently with the certified data.

2-9.7 Medical Records Requirements

The CONTRACTOR shall maintain, and shall require contracted providers, subcontractors to maintain medical records in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review, administrative, civil and/or criminal investigations and/or prosecutions. Medical records are to be maintained at the site where medical services are provided for each member enrolled under this Contract. The CONTRACTOR shall have policies and distribute policies to practice sites that address:

1. Confidentiality of medical records;
2. Medical record documentation standards;
3. An organized medical record keeping system and standards for the availability of medical records, including but not limited to:
 - (a) Enrollees and their representatives shall be given access to the enrollees' medical records, to the extent and in the manner provided by T.C.A. Sections 63-2-101 and 63-2-102, and, subject to reasonable charges, be given copies thereof upon request;

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- (b) When a patient-provider relationship with a TennCare primary care provider ends and the enrollee requests that medical records be sent to a second TennCare provider who will be the enrollee's primary care case manager or gatekeeper, the first provider shall not charge the enrollee or the second provider for providing the medical records.
4. Performance goals to assess the quality of medical record keeping; and
5. CONTRACTOR medical record keeping policies and practices must be consistent with 42 CFR 456 and current NCQA Standards for medical record documentation.

2-9.8 Quality Monitoring/Quality Improvement (QM/QI) Program

The CONTRACTOR shall have a written Quality Improvement (QI) Program which clearly defines its quality improvement structures and processes and assigns responsibility to appropriate individuals. This Program shall use as a guideline the current NCQA Standards and Guidelines for the Accreditation of MCOs and shall include the MCO's plan for improving patient safety. The CONTRACTOR shall agree to achieve and maintain NCQA Accreditation. NCQA Accreditation must be achieved by December 31, 2006 and maintained thereafter. Additionally, for new MCOs contracting with TENNCARE, the Program shall be approved by TENNCARE prior to the enrollment of any TennCare enrollees. Any changes to the QI program structure shall require prior written approval from TENNCARE. The QI Program Description and associated work plan shall be submitted to TENNCARE annually for approval along with the Annual Evaluation of QI Program. The QI evaluation of the QI Program for the prior year, the revised QI Program Description and associated Work Plan shall be submitted to TENNCARE following approval by the CONTRACTOR's Quality Improvement Committee, no later than April 15th each year.

1. QM/QI Meeting Requirements

The CONTRACTOR shall provide the Chief Medical Officer of TENNCARE with ten (10) days advance notice of all regularly scheduled meetings of the Quality Improvement Committee and Peer Review Committee. The Chief Medical Officer of TENNCARE, or his/her designee, may attend the Quality Improvement Committee and/or Peer Review Committee meetings at his/her option. In addition, written minutes shall be kept of all meetings of the Quality Improvement Committee and Peer Review Committees. A copy of the signed and dated written minutes for each meeting shall be available on-file after the completion of the following committee meeting in which the minutes are approved and shall be available for review upon request and during the annual on-site EQRO review and/or NCQA Accreditation review.

2. Clinical and Service Quality Improvement/Performance Improvement Activities

The CONTRACTOR shall perform three (3) clinical and two (2) service quality improvement activities relevant to the enrollee population or as required to obtain NCQA Accreditation. Two of the three clinical activities shall be determined by TENNCARE. The TENNCARE selected clinical quality improvement activity topics are diabetes and maternity management. The following must be documented for each activity and CMS protocols for performance improvements projects (PIPs) must be met:

- Rationale for selection as a quality improvement activity
- Specific population targeted, include sampling methodology if relevant
- Metrics to determine meaningful improvement and baseline measurement
- Specific interventions (enrollee and provider)
- Relevant clinical practice guidelines
- Date of re-measurement

The CONTRACTOR shall electronically submit Quality Improvement Activity Forms as required by NCQA. These forms are available at www.NCQA.org.

Amendment 12 (cont.)

Further, the CONTRACTOR shall update and submit quarterly the Quality Improvement Activities Update Grid along with a brief narrative and barrier analysis explaining any delays encountered for any of the planned activities and the plan for completing any delayed scheduled activities.

3. Clinical Practice Guidelines

The CONTRACTOR shall select at least four (4) evidence-based clinical practice guidelines from recognized sources that are relevant to the enrollee population. Guidelines must be distributed to all appropriate providers. The MCO shall measure performance against at least two (2) important aspects of each of the four (4) clinical practice guidelines annually. The guidelines must be reviewed and any revisions distributed to appropriate providers at least every two (2) years or whenever national guidelines change.

4. Performance Indicators

Performance indicator results shall be reported to TENNCARE within the Annual Evaluation of the Quality Improvement Program. Audited HEDIS and CAHPS results, including audit findings, shall be reported to TENNCARE by June 15th of each calendar year.

The CONTRACTOR's QI Work Plan shall identify benchmarks and set achievable performance goals for each selected quality measure. The source of the benchmark should be identified, i.e., Quality Compass. To be considered meaningful, the CONTRACTOR must demonstrate improvement against the baseline measure as indicated:

Baseline Rate	Minimum Effect Size
0-59	At least a 6 percentage point increase
60-74	At least a 5 percentage point increase
75-84	At least a 4 percentage point increase
85-92	At least a 3 percentage point increase
93-96	At least a 2 percentage point increase
97-100	At least a 1 percentage point increase

The CONTRACTOR's failure to demonstrate meaningful improvement toward benchmark levels of performance shall result in the CONTRACTOR being required to implement a corrective action plan as described in Section 2-16.

5 EPSDT(TENNderCare)

The CONTRACTOR shall demonstrate at least a 10 percentage-point improvement over the average MCO fiscal year 2000 EPSDT adjusted periodic screening percentage (APSP) for SSI children and at least a 10 percentage-point improvement over the average fiscal year 2000 APSP EPSDT screening rate for all other children enrolled in TennCare Select.

To encourage significant improvement in EPSDT screening rates, the CONTRACTOR may recommend a program designed to increase screening rates through the use of financial incentives. TennCare must approve the program design and amount of any payments prior to distribution.

As specified at 2-4.9, the CONTRACTOR shall contract with each Department of Health for the provision of EPSDT services in the community service area(s) in which it is authorized to serve until such time as it obtains an APSP of eighty percent (80%).

6. Credentialing and Recredentialing

Amendment 12 (cont.)

The CONTRACTOR utilizes current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent practitioners with whom it contracts or employs and who fall within its scope of authority and action. The CONTRACTOR shall further adhere to the credentialing requirements described in Section 2-4.7.6 of this Contract regarding non-contract providers.

7 NCQA Accreditation

NCQA Accreditation must be achieved by December 31, 2006 and maintained thereafter. In order to assure that the CONTRACTOR is making forward progress, TENNCARE shall require the following information and/or benchmarks be met:

EVENT	REQUIRED DEADLINE
CALENDAR YEAR 2005	
Submit preliminary HEDIS data to EQRO as required by the CRA	July 1, 2005
Submit locked DST to NCQA	July 15, 2005
Purchase NCQA ISS Tool for 2006 MCO Accreditation Survey	August 1, 2005
Utilize the NCQA approved Quality Improvement Activity Form to submit baseline data, barrier analysis, and planned interventions for three (3) Clinical and two (2) Service Improvement Studies selected by MCO.	September 15, 2005
NCQA Accreditation Survey Application Submitted and Pre Survey Fee paid	November 15, 2005
Copy of signed contract with NCQA approved vendor to perform 2006 CAHPS Survey to TENNCARE	November 15, 2005
Copy of signed contract with NCQA approved vendor to perform 2006 HEDIS Audit to TENNCARE	November 15, 2005
Submit copy of signed NCQA Survey Contract to TENNCARE	December 15, 2005
Notify TennCare of date for ISS Submission and NCQA Onsite review	December 31, 2005
CALENDAR YEAR 2006	
HEDIS Baseline Assessment Tool completed and submitted to Contracted HEDIS Auditor and TennCare	February 15, 2006
Audited Medicaid HEDIS and CAHPS results submitted to NCQA and TennCare	June 15, 2006
Finalize preparations for NCQA Survey (final payment must be submitted to NCQA 60 days prior to submission of ISS.	July 1 – September 15, 2006
Submit ISS to NCQA	No later than September 18, 2006
NCQA Survey Completed and copy of NCQA Final Report to TennCare: <ul style="list-style-type: none"> • Excellent, Commendable, or Accredited • Provisional -- Corrective Action required to achieve status of Excellent, Commendable, or Accredited; resurvey within 12 months. Plan of Corrective Action addressing deficiencies noted by NCQA to TennCare within thirty (30) days of receipt of Final Report from NCQA. Provisional status may result in the assessment of liquidated damages or termination of this Agreement. 	December 31, 2006

Amendment 12 (cont.)

<ul style="list-style-type: none"> • Accreditation Denied – Results in termination of this Agreement 	
CALENDAR YEAR 2007	
Complete NCQA Reconsideration Process (if necessary)	January 1, 2007- March 30, 2007
Complete Provisional NCQA Accreditation Resurvey NOTE: Provisional NCQA Accreditation may result in the assessment of liquidated damages or termination of this Agreement	December 31, 2007
Maintain NCQA Accreditation	On-going
Audited Medicaid HEDIS and CAHPS results submitted to NCQA and TennCare	June 15, 2007
Notify TENNCARE of any revision to accreditation status based HEDIS score	Annually immediately upon notification by NCQA
CALENDAR YEAR 2008	
Maintain NCQA Accreditation	On-going
Audited Medicaid HEDIS and CAHPS results submitted to NCQA and TennCare	June 15, 2008
Notify TENNCARE of any revision to accreditation status based HEDIS score	Annually immediately upon notification by NCQA

The CONTRACTOR may obtain additional payments for the successful achievement of NCQA Accreditation as described in Section 5-1.h of this Agreement.

If the CONTRACTOR consistently fails to meet the timelines as described above, the CONTRACTOR shall be considered to be in breach of the terms of this Agreement and may be subject to termination in accordance with Section 6-2.2 of this Agreement. Further, failure to achieve specified benchmarks or reporting requirements, as described in Section 6-8.2.2 shall result in damages as described therein.

Failure to obtain NCQA Accreditation by December 31, 2006 and maintain Accreditation thereafter, shall be considered a breach of this Agreement and shall result in termination of this Agreement in accordance with the terms set forth in Section 6-2.2 of this Agreement. Achievement of Provisional accreditation status shall require a corrective action plan and may result in termination of this Agreement.

2-9.9. Third Party Resources (TPL)

The CONTRACTOR shall be the payer of last resort for all medical services in accordance with federal regulations. The CONTRACTOR shall exercise, full assigned benefit rights and/or subrogation rights as applicable and shall be responsible for making every reasonable effort to determine the legal liability of third parties to pay for services rendered to enrollees under this Contract and recover any such liability from the third party. The CONTRACTOR shall post all third party payments to claim level detail by enrollee. Unless otherwise indicated below, claims for which the CONTRACTOR's files indicate TPL exists, but does not reflect third party payment shall be denied. Further, in accordance with Section 2-10.2, the CONTRACTOR shall report to TENNCARE any information regarding an enrollee's third party resources in a format and media as described by TENNCARE.

Amendment 12 (cont.)

1. If the CONTRACTOR has determined that TPL exists for part or all of the services administered directly by the CONTRACTOR the CONTRACTOR shall make reasonable efforts to recover from third party liable sources the value of services rendered.
2. If the CONTRACTOR has determined that TPL exists for part or all of the services provided to an enrollee by a provider, the CONTRACTOR shall pay the provider only the amount, if any, by which the provider's allowable claim exceeds the amount of TPL. The CONTRACTOR and all providers and subcontractors shall not require any cost sharing responsibilities for TennCare covered services except to the extent that cost sharing responsibilities are required for those services by TENNCARE.
3. The CONTRACTOR may not withhold payment for services provided to a member if TPL or the amount of liability cannot be determined, or payment will not be available within a reasonable time. Except for the claims described below, if the probable existence of TPL has been established at the time the claim is filed, the CONTRACTOR must reject the claim and return it to the provider for a determination of the amount of any third party payment. The claims exceptions are EPSDT, prenatal or preventive pediatric care, and all claims covered by absent parent maintained insurance under Part D of Title IV of the Social Security Act. These claims will be paid at the time presented for payment by the provider and the CONTRACTOR shall bill the responsible third party. When the amount of payment is determined, the CONTRACTOR shall pay the claim at the rate allowed under the CONTRACTOR's payment schedule. In no instance shall the amount of the third party payment and the CONTRACTOR's payment exceed the provider's contracted TennCare rate.
4. All funds recovered from third parties will be treated as offsets to claims payments. The CONTRACTOR shall report all cost avoidance values to TENNCARE in accordance with federal guidelines and as described in Section 2-10. of this Contract.
5. TennCare Cost sharing responsibilities permitted pursuant to Section 2-4.10 of this Contract shall not be considered third party resources for purposes of this requirement.
6. The CONTRACTOR shall provide third party resource (TPR) data to any provider having a claim denied by the CONTRACTOR based upon a TPR.
7. The CONTRACTOR shall provide any information necessary in a format and media described by TENNCARE and shall cooperate in any manner necessary, as requested by TENNCARE, with TENNCARE and/or a Cost Recovery Vendor at such time that TENNCARE acquires said services.
8. Third party resources shall include subrogation recoveries. The CONTRACTOR shall be required to seek subrogation amounts regardless of the amount believed to be available as required by federal Medicaid guidelines. The amount of any subrogation recoveries collected by the CONTRACTOR outside of the claims processing system shall be the property of the State. On a monthly basis, the CONTRACTOR shall report to the State the amount of any subrogation recoveries collected outside the claims processing system received during the previous month. The next remittance request subsequent to this monthly report shall be reduced by the value of the subrogation recoveries reported.
9. The CONTRACTOR shall not make payment on a claim that has been denied by a third party payor when the reason for denial is the provider or enrollee's failure to follow prescribed procedures, including but not limited to, failure to obtain prior authorization, timely filing, etc., unless otherwise directed by TENNCARE to do so.

Amendment 12 (cont.)

10. TENNCARE may require a TennCare contracted TPL vendor to review paid claims that are over ninety (90) days old and pursue TPL (excluding subrogation) for those claims that do not indicate recovery amounts in the CONTRACTOR's reported encounter data.

Failure to seek, make reasonable effort to collect and report third party recoveries shall result in liquidated damages as described in Section 6-8 of this Contract. It shall be the CONTRACTOR's responsibility to demonstrate, upon request, to TENNCARE that reasonable effort has been made to seek, collect and/or report third party recoveries. TENNCARE shall have the sole responsibility for determining whether or not reasonable efforts have been demonstrated. Said determination shall take into account reasonable industry standards and practices.

2-9.10. Location of Non-responsive TennCare Eligibles

The CONTRACTOR agrees to attempt to locate "non-responsive TennCare eligibles" that have been enrolled in the CONTRACTOR's plan. Non-responsive TennCare eligibles are persons identified by TennCare who have not responded to re-verification attempts and who have not (and whose family members have not) accessed services during the period of review. Within 90 days of identification, the CONTRACTOR shall attempt to reach each non-responsive TennCare eligible identified by TennCare to the CONTRACTOR and assigned to TennCare Select effective July 1, 2001. The CONTRACTOR shall attempt to reach each non-responsive TennCare eligible telephonically using the phone number provided by TennCare. Upon placement of the call, if the CONTRACTOR receives a message that the phone number has been changed, the CONTRACTOR shall update the enrollee's phone number in its system and make at least three documented attempts to contact said enrollee at the new number to obtain the enrollee's new address. If successful, the CONTRACTOR will forward this information to TennCare via the Weekly Enrollee Information Report as well as a Non-Responsive File via CD Rom which shall include additional data elements as described in this Section. If TennCare does not provide a telephone number, the CONTRACTOR shall make and document at least one attempt to contact the non-responsive TennCare eligible through other publicly available information resources. In addition, the CONTRACTOR shall monitor claims activity for non-responsive TennCare eligibles. In the event the CONTRACTOR receives a claim for payment on behalf of a non-responsive TennCare eligible, the CONTRACTOR shall contact the provider and request the enrollee's phone number and address on file with the provider. The CONTRACTOR shall make at least three documented attempts to contact the enrollee at the location provided by the provider to confirm the enrollee's address. Once confirmed, the CONTRACTOR shall forward this information to TennCare via the Weekly Enrollee Information Report as well as a Non-Responsive File via CD Rom which shall include additional data elements as described in this Section. The CONTRACTOR shall complete this process within 45 days for other non-responsive TennCare eligible as they are identified by TennCare to the CONTRACTOR.

2-9.11. Claims Processing Requirements

1. Timeliness of Payments

The CONTRACTOR shall have in place, an automated claims processing system capable of accepting and processing claims submitted electronically with the exception of claims that require written documentation to justify payment (e.g., hysterectomy/sterilization consent forms, Certification for Medical Necessity for Abortion, necessary operative reports, etc.). To the extent that the CONTRACTOR compensates providers on a fee for service or other basis requiring the submission of claims as a condition to payment, the CONTRACTOR shall process, as described herein, the provider's claims for covered benefits provided to enrollees consistent with applicable CONTRACTOR policies and procedures and the terms of this Contract. The CONTRACTOR shall ensure that ninety percent (90%) of claims for payment for services delivered to a TennCare enrollee (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) days of the receipt of such claims. The CONTRACTOR shall process, and if appropriate pay, within sixty (60) days

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ninety-nine point five percent (99.5%) of all provider claims for services delivered to an enrollee in the TennCare Program. The terms "processed and paid" are synonymous with terms 'process and pay' of Tennessee Code Annotated § 56-32-226(b)(1)(A) and (B). If a claim is partially or totally denied on the basis the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written notice must specifically identify all such information and documentation. Resubmission of a claim with further information and/or documentation shall constitute a new claim for purposes of establishing the time frame for claims processing.

To the extent that the provider agreement requires compensation of a provider on a monthly fixed fee basis or on any other basis that does not require the submission of a claim as a condition to payment, such payment shall be made to the provider by no later than (i) the time period specified in the contract between the provider and the CONTRACTOR or subcontractor, or if a time period is not specified in the contract (ii) the tenth (10th) day of the calendar month if the payment is to be made by a subcontractor, or (iii) if the CONTRACTOR is required to compensate the provider directly, within five (5) calendar days after receipt of the fixed administrative fee payment and supporting Remittance Advice information from TENNCARE.

The CONTRACTOR shall contract with independent reviewers for the purposes to review disputed claims as provided by T.C.A., Section 56-32-226.

2. Claims Payment Accuracy – Minimum Audit Procedures

The quarterly claims payment accuracy percentage is self-reported and is based on an audit conducted by the internal audit staff. The audit will utilize a random sample of all "processed or paid" claims upon initial submission in each quarter (the terms "processed and paid" are synonymous with terms 'process and pay' of Tennessee Code Annotated § 56-32-226(b)(1)(A) and (B)).

A minimum sample of size of 300 claims randomly selected from the entire population of electronic and paper claims processed or paid upon initial submission for the quarter tested is required. Combining the results of minimum sub-samples of 100 randomly selected from the entire population of claim processed and paid upon initial submission for each month in the quarter is acceptable. The minimum attributes to be tested for each claim selected must include:

- Claim data correctly entered into the claims processing system
- Claim is associated to the correct provider
- Service obtained the proper authorization
- Member eligibility at processing date correctly applied
- Allowed payment amount agrees with contracted rate
- Duplicate payment of the same claim has not occurred
- Denial reason applied appropriate
- Copayment application considered and applied
- Effect of modifier codes correctly applied
- Processing considered if service subject to benefit limits considered and applied
- Other insurance properly considered and applied

For audit and verification purposes, the population of claims should be maintained. Additionally, the results of testing at a minimum should be documented to include:

- Results for each attribute tested for each claim selected
- Amount of overpayment or underpayment for claims processed or paid in error
- Explanation of the erroneous processing for each claim processed or paid in error
- Determination if the error is the result of keying errors or the result of errors in the configuration or table maintenance of the claims processing system

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- Claims processed or paid in error have been corrected

3. **Electronic Billing**

The CONTRACTOR shall provide the capability of electronic billing. The CONTRACTOR or any entities acting on behalf of the CONTRACTOR, shall not charge providers for filing claims electronically. However, this provision shall not be construed to imply that providers may not be responsible for payment of applicable line fees and/or charges. The CONTRACTOR shall comply at all times with standardized paper billing forms/format as follows:

<u>Claim Type</u>	<u>Claim Form</u>
Professional	CMS 1500
Institutional	UB-92
Pharmacy	NCPDP (Edit Format)
Dental	ADA

4. **Standard Forms and Billing Instructions**

The CONTRACTOR shall not revise or modify the standardized forms or format itself specified in item 2 above. Further, the CONTRACTOR agrees to adopt national EMC standards and standardized instructions and definitions that are consistent with industry norms for the forms identified above when developed by TENNCARE in conjunction with appropriate workgroups. This shall include, but not be limited to, federally required safeguard requirements including signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR 455.18 and 455.19 which requires a statement that the provider certifies that s/he is aware that payment is from Federal and State funds and anyone who misrepresents or falsifies essential Medicaid claims information may be prosecuted under Federal and State laws.

5. **Edits**

The CONTRACTOR shall perform front end system edits, including but not limited to, TPL, medical necessity (e.g., appropriate age/sex for procedure) and post-payment review on a sample of claims to ensure services provided were medically necessary. The CONTRACTOR must have a staff qualified, medically trained and appropriately licensed personnel, consistent with accreditation standards of NCQA, JCAHO or URAC whose primary duties are to assist in evaluating claims for medical necessity.

6. **Timely Filing**

Consistent with the requirements outlined in Section 2-18.v of this Contract, the CONTRACTOR shall not deny provider claims on the basis of timely filing in situations regarding coordination of benefits or subrogation in which case the provider is pursuing payment from a third party or if an enrollee is enrolled in the plan with a retroactive eligibility date. In situations of third party benefits, the minimum and maximum time frames for filing a claim shall begin on the date that the third party documented resolution of the claim. In situations of enrollment in the plan with a retroactive eligibility date, the minimum and maximum time frames for filing a claim shall begin on the date that the CONTRACTOR receives notification from TENNCARE of the enrollee's eligibility.

7. **HIPAA Compliance**

The CONTRACTOR agrees to maintain compliance with the Health Insurance Portability and Accountability Act (HIPAA). Further, the CONTRACTOR agrees that at such time that the Steering Committee presents TENNCARE with recommendations concerning claims billing and processing that are consistent with industry norms, the CONTRACTOR shall comply with said recommendations within one hundred and eighty (180) days from notice by TENNCARE to do so.

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8. Eligibility for Services

The CONTRACTOR shall confirm eligibility on each participant as claims are submitted, on the basis of the eligibility information provided by the State or DCS (via the adhoc reporting process approved by TennCare) that applies to the period during which the charges were incurred. The CONTRACTOR shall process said claims, in an accurate manner in accordance with this Contract.

9. EPSDT (TENNderCare) Reimbursement

For provider agreements executed after October 1, 2002, the CONTRACTOR shall reimburse EPSDT (TENNderCare) services on a fee-for-service basis.

10. Explanation of Benefits (EOBs)

The CONTRACTOR shall be responsible for generating and mailing EOBs to TennCare enrollees in accordance with guidelines described by TENNCARE. The MCO will omit any claims in the EOB file that are associated with sensitive services. Each MCO, with guidance from TennCare, will develop "sensitive services" logic to be used in eliminating these claims from generating an EOB. At a minimum, EOBs shall be designed to address CMS requirements found in 42 CFR Sections 455.20 and 433.116 as well as requirements associated with a change in TennCare policy and shall include; Claims for services with benefit limits, Claims with enrollee cost sharing, denied claims with enrollee responsibility, and a sampling of paid claims (excluding ancillary and anesthesia services).

Regarding the paid claims, the CONTRACTOR shall stratify the sample to ensure that all provider types (or specialties) are represented in the pool of generated EOBs. To the extent that the MCO considers a particular specialty (or provider) to warrant closer scrutiny, the MCO may over sample the group. The paid claims sample should be a minimum of 25 claims per check run (or 100 claims a month).

Based on the EOBs sent to the TennCare enrollees, the MCO will track any complaints received from enrollees and resolve the complaints according to MCO established policies and procedures. The resolution may be enrollee education, provider education, or referral to TBI/OIG. The MCO will use the feedback received to modify or enhance the EOB sampling methodology. Reporting of this process shall be described in Section 2-10 of this Contract.

11. Remittance Advice to Providers

The CONTRACTOR shall provide a HIPAA compliant electronic status report indicating the disposition for every adjudicated claim for each claim type submitted by providers seeking payment as well as fixed administrative fee payments generated and paid by the MCO. The status report shall contain appropriate explanatory remarks related to payment or denial of the claim, including but not limited to TPL data. If a claim is partially or totally denied on the basis the provider did not submit any required information or documentation with the claim, then the remittance advice must specifically identify all such information and documentation.

In accordance with 42 CFR 455.18 and 455.19, the following statement must be including on each remittance advice sent to providers: "I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, documents, or concealment of a material fact, may be prosecuted under applicable Federal and/or State laws."

12. Encounter Data

The CONTRACTOR shall submit encounter data to TENNCARE in accordance with Section 2-10. Encounter data shall include detailed information, including but not limited to applicable cost share

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responsibilities, TPL collections and shall contain all data elements required by TENNCARE and described in Attachment XI, Exhibit G.

13. Overpayment due to CONTRACTOR Error

The CONTRACTOR shall use its best efforts to recover overpayment of benefits that result from errors of the CONTRACTOR. Should the CONTRACTOR inadvertently make payment, arising from errors in overpayment, the amount of overpayment actually recovered should be credited to the State within forty-five (45) calendar days after recovery of the overpaid funds by the CONTRACTOR. In the event any overpayment is not recovered within 90 calendar days of discovery of the overpayment – and if the State has already made payment of the claims that included the overpayment – the CONTRACTOR will credit the State for the amount of the overpayment by the ninetieth (90) day.

14. Overpayment due to Provider Error

Overpayments due to provider billing errors and provider fraud or fraud of any other type, other than fraud by employees or contractors of the CONTRACTOR, will not be considered overpayments due to errors of the CONTRACTOR. In addition, the State will not hold the CONTRACTOR responsible for overpayment caused by the State's omission or errors in certifying eligibility; however, the CONTRACTOR is required to assist in recovery of overpayments due to provider billing errors or due to State errors or omissions.

15. Liquidated Damages/Sanctions

Failure to meet claims processing requirements shall result in the application of liquidated damages in the amount of \$10,000 per month for each month the CONTRACTOR is out of compliance.

2-9.12. Network Management

The CONTRACTOR shall provide or assure the provision of all covered services specified in Section 2-3.1 of this Contract. The CONTRACTOR may provide these services directly or may enter into written agreements with providers and provider subcontracting entities or organizations who will provide services to the enrollees in exchange for payment by the CONTRACTOR for services rendered.

1. Should the CONTRACTOR elect to contract with providers for the provision of covered services, the CONTRACTOR shall adhere to the following:
 - (a) The CONTRACTOR shall not execute provider agreements with providers who have been excluded from participation in the Medicare and/or Medicaid programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with the TENNCARE program.
 - (b) The CONTRACTOR shall have in place written policies and procedures for the selection and/or retention of providers and policies and procedures must not discriminate against particular providers that service high risk populations or specialize in conditions that require costly treatment.
 - (c) The CONTRACTOR shall not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. The CONTRACTOR's ability to credential providers as well as maintain a separate network and not include any willing provider is not considered discrimination.

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- (d) If the CONTRACTOR declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.
 - (e) The CONTRACTOR shall maintain all provider agreements in accordance with the provisions specified in Title 42, CFR §438.12, 438.214 and Section 2-18 of this Contract.
 - (f) The CONTRACTOR shall make provider payments in accordance with Section 5 of this Contract and shall negotiate changes in reimbursement rates as required by TENNCARE.
2. Section 2-9.4.1 shall not be construed to:
- (a) Require the CONTRACTOR to contract with providers beyond the number necessary to meet the needs of its enrollees;
 - (b) Preclude the CONTRACTOR from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or
 - (c) Preclude the CONTRACTOR from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to enrollees.
3. The CONTRACTOR may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient for the following:
- (a) The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self administered;
 - (b) Any information the enrollee needs in order to decide among all relevant treatment options;
 - (c) The risks , benefits, and consequences of treatment or non-treatment; or
 - (d) The enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
4. The CONTRACTOR shall ensure that punitive action is not taken against a provider who either requests an expedited resolution or supports an enrollee's appeal.
5. The CONTRACTOR shall notify and make TENNCARE and TDCI TennCare Division aware of any operations or plans to operate a Physician Incentive Plan (PIP). Prior to implementation of any such plans, CONTRACTOR shall submit to TDCI TennCare Division any provider agreement templates or subcontracts that involve a PIP for review as a material modification. CONTRACTOR shall not implement a PIP in the absence of TDCI TennCare Division review and approval, which review will include review for compliance with applicable state and federal law. If the CONTRACTOR operates a PIP, the CONTRACTOR shall assure that no specific payment be made directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual. If the CONTRACTOR operates a PIP, upon TENNCARE's request, the CONTRACTOR must report descriptive information about its incentive plan in sufficient detail to enable TENNCARE to adequately monitor the CONTRACTOR. The information that may be requested shall include, but not be limited to, the following:
- (a) Whether services not furnished by the physician or physician group are covered by the incentive plan.
 - (b) The type or types of incentive arrangements, such as, withholds, bonus, capitation.

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- (c) The percent of any withhold or bonus the plan uses.
 - (d) Assurance that the physicians or physician group has adequate stop-loss protection, and the amount and type of stop-loss protection.
 - (e) The patient panel size and, if the plan uses pooling, the pooling method.
 - (f) If the CONTRACTOR is required to conduct enrollee surveys, a summary of the survey results.
6. For purposes of network management, the CONTRACTOR shall, at a minimum, adhere to and/or provide for the following:
- (a) The CONTRACTOR shall notify all network providers to file claims associated with their services directly with the CONTRACTOR, or its subcontractors, on behalf of TennCare enrollees.
 - (b) The CONTRACTOR shall notify all network providers of and enforce compliance with all provisions relating to utilization management procedures.
 - (c) PCP Profiling. The CONTRACTOR shall profile TennCare PCP's. A summary of Provider profiling activities will be provided to the TennCare Chief Medical Officer quarterly. The summary will include a listing of PCPs whose profiling revealed practice patterns greater than or equal to two standard deviations from the norm within the CONTRACTOR's network. The summary should include specific actions taken for identified outliers. PCP profiling will include, but not be limited to, the following:
 - (1) Out-of-Network Utilization. The CONTRACTOR shall maintain a procedure to identify and evaluate enrollee out-of-network utilization by PCP panel.
 - (2) Specialist Referrals. The CONTRACTOR shall maintain a procedure to identify and evaluate enrollee Specialty provider utilization by PCP panel.
 - (3) Emergency Room Utilization. The CONTRACTOR shall maintain a procedure to identify and evaluate enrollee emergency room utilization by PCP panel. Individual enrollees who establish a pattern of accessing emergency room services should be referred to case management for follow-up.
 - (4) Inpatient Admissions. The CONTRACTOR shall maintain a procedure to identify and evaluate enrollee utilization of inpatient services by PCP panel.
 - (5) Pharmacy Utilization. At a minimum, the CONTRACTOR shall comply with the following:
 - (a) Generic versus Brand Name. The CONTRACTOR shall maintain a procedure to incorporate pharmacy utilization (generics versus brand names) into the PCP profile.
 - (b) Outlier Reports for Narcotic Prescriptions. TENNCARE shall provide the CONTRACTOR a semiannual report listing TennCare providers who appear to be outliers with regard to the numbers and percentages of narcotic prescriptions they write. The CONTRACTOR shall assess the prescribing practices of all contracted providers and report back to the Bureau regarding their findings. The report will either provide assurance that the prescriber appears to be

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practicing their specialty in accordance with acceptable standards of care or will provide a plan to address any identified concern.

- (6) Advanced Imaging Procedures. The CONTRACTOR shall maintain a procedure to identify and evaluate utilization of advanced imaging procedures by PCP panel. Advanced Imaging Procedures include: PET Scans; CAT Scans and MRIs.
- (d) Practice Pattern Analysis. The CONTRACTOR shall analyze utilization data, including but not limited to, information provided to the CONTRACTOR by TENNCARE, and report back outlier information as requested by TENNCARE.

2-9.13. Fraud and Abuse

The Tennessee Bureau of Investigation Medicaid Fraud Control Unit (TBI MFCU) is the state agency responsible for the investigation of provider fraud and abuse in the State Medicaid program (TennCare).

The Office of Inspector General (OIG) has the primary responsibility to investigate TennCare enrollee fraud and abuse.

The CONTRACTOR shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities. The CONTRACTOR shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the CONTRACTOR in preventing and detecting potential fraud and abuse activities. Failure to comply with the fraud and abuse requirements set forth in this Contract may result in liquidated damages as described in Section 6-8 of this Contract.

a. Reporting and Investigating Suspected Fraud and Abuse

- 1. The Contractor shall cooperate with all appropriate State and Federal Agencies, including TBI MFCU and/or OIG, in investigating fraud and abuse. In addition, the Contractor shall fully comply with the provisions of Tennessee Code Annotated Sections 71-5-2601 and 71-5-2603 in performance of its' obligations under this Agreement.
 - i. Fraud and abuse in the administration of the program. Suspected fraud and abuse in the administration of the program shall be reported to TBI MFCU and/or OIG.
 - ii. Provider fraud and abuse. All confirmed or suspected provider fraud and abuse shall immediately be reported to TBI MFCU.
 - iii. Enrollee fraud and abuse. All confirmed or suspected enrollee fraud or abuse shall be reported immediately to OIG.
- 2. CONTRACTOR shall use the Fraud Reporting Forms attached to this Contract, or such other form as may be deemed satisfactory by the agency to whom the report is to be made under the terms of this Contract.
- 3. Pursuant to TCA § 71-5-2603(c) CONTRACTOR shall be subject to a civil penalty, to be imposed by OIG, for willful failure to report fraud by recipients, enrollees, applicants, or providers to OIG or MFCU, as appropriate.
- 4. After reporting fraud or suspected fraud and/or suspected abuse and/or confirmed abuse, CONTRACTOR shall promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud and abuse, but shall not:

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- i. contact the subject of the investigation about any matters related to the investigation,
 - ii. enter into any settlement or agreement regarding the incident, or
 - iii. accept any money or other thing of value offered in connection with the incident unless prior approval is obtained from the agency to whom the incident was reported, or to another agency designated by the agency that received the report.
5. The CONTRACTOR shall promptly provide the results of its preliminary investigation to the agency to whom the incident was reported, or to another agency designated by the agency that received the report.
6. CONTRACTOR shall cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation shall include providing, upon request, information, access to records, and access to interview CONTRACTOR employees and consultants, including but not limited to those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation.
7. The State shall not transfer its law enforcement functions to the CONTRACTOR.
8. The Contractor and health care providers, whether participating or non-participating providers, shall, upon request and as required by this Contract or state and/or federal law, make available to the TBI MFCU/OIG any and all administrative, financial and medical records relating to the delivery of items or services for which TennCare monies are expended. In addition, the TBI MFCU/OIG shall, as required by this CONTRACT or state and/or federal law, be allowed access to the place of business and to all TennCare records of any Contractor or health care provider, whether participating or non-participating, during normal business hours, except under special circumstances when after hour admission shall be allowed. Special circumstances shall be determined by the TBI MFCU/OIG.
9. The Contractor shall include in any of its provider agreements a provision requiring, as a condition of receiving an amount of TennCare payment, the provider must comply with Section 2-9.9 of this CONTRACT.
10. Except as described in Section 2-4.7.6 of this Contract, nothing herein shall require the CONTRACTOR to assure non-participating providers are compliant with TENNCARE contracts or state and/or federal law.

b. Fraud and Abuse Compliance Plan

1. The CONTRACTOR shall have a written Fraud and Abuse compliance plan.
2. The fraud and abuse compliance plan shall:
 - i. Require that the reporting of suspected and/or confirmed fraud and abuse be done as required by this Contract.
 - ii. Ensure that all officers, directors, managers and employees know and understand the provisions of the CONTRACTOR's fraud and abuse compliance plan;
 - iii. Contain procedures to prevent and detect fraud and abuse in the administration and delivery of services under this contract:

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- iv. Include a description of the specific controls in place for prevention and detection of fraud and abuse, such as:
 - a. Claims edits;
 - b. Post-processing review of claims;
 - c. Provider profiling and credentialing;
 - d. Prior authorization;
 - e. Utilization management;
 - f. Relevant subcontractor and provider agreement provisions;
 - g. Written provider and enrollee material regarding fraud and abuse referrals.
 - v. Contain provisions for the confidential reporting of plan violations to the designated person as described in this Contract;
 - vi. Contain provisions for the investigation and follow-up of any suspected or confirmed fraud and abuse, even if already reported, and/or compliance plan reports;
 - vii. Ensure that the identities of individuals reporting violations of the plan are protected and that there is no retaliation against such persons;
 - viii. Contain specific and detailed internal procedures for officers, directors, managers and employees for detecting, reporting, and investigating fraud and abuse compliance plan violations;
 - ix. Require any confirmed or suspected provider fraud and abuse under state or federal law be reported to TBI MFCU and that enrollee fraud and abuse be reported to the OIG;
 - x. Ensure that no individual who reports plan violations or suspected fraud and abuse is retaliated against.
3. The CONTRACTOR shall comply with the applicable requirements of the Model Compliance Plan for HMOs when the final model plan is issued by the U.S. Department of Health and Human Services, the Office of Inspector General (OIG).
4. The CONTRACTOR shall designate an officer or director in its organization who has the responsibility and authority for carrying out the provisions of the fraud and abuse compliance plan.
5. The CONTRACTOR shall submit an annual report to the Bureau of TennCare, Office of Contract Compliance and Performance, summarizing the results of its fraud and abuse compliance plan and other fraud and abuse prevention, detection, reporting, and investigation measures as required by 2-9.9 of this Contract. The report should cover results for the year ending June 30 and be submitted by September 30 each year. This information in this report shall be provided in accordance with and in a format as described in the CONTRACTOR's approved compliance plan.

21. Section 2-10.2 shall be amended by adding a new 2-10.2.7 which shall read as follows:

7. Enrollee EOB Reporting

In accordance with Section 2-9.11.10 of this Contract, a quarterly report will be sent to the Office of Contract Compliance and Performance delineating the number of EOBs sent by category, enrollee

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complaints, and complaint resolution (including referral to TBI/OIG). The quarterly report is due thirty (30) days after the end of the quarter.

22. Section 2-10.5 shall be deleted and replaced in its entirety so that the amended Section 2-10.5 shall read as follow:

2-10.5. Medical Services Payment Reporting

1. Individual Encounter Reporting

Individual encounter/claim data shall be reported in a standardized format as specified by TENNCARE and transmitted electronically to TENNCARE on a weekly basis. In the event a national standardized encounter reporting format is developed, the CONTRACTOR agrees to implement this format if directed to do so by TENNCARE. The minimum data elements required to be provided are identified in Attachment XII, Exhibit G of this Contract.

The CONTRACTOR shall submit encounter data to the state during the term of this Agreement and beyond, until all such claims incurred during the term of this Agreement have been paid. Data shall be submitted in the format specified by TennCare. The CONTRACTOR shall ensure that all claims processed for payment have industry standard diagnosis and procedure codes and valid Medicaid provider numbers.

2. TPL Reporting

- (a) Cost Avoidance Value Reporting. The CONTRACTOR shall report all funds for which the CONTRACTOR does not pay a claim due to TPL coverage or Medicare coverage on a frequency and in a format and media described by TENNCARE. The CONTRACTOR shall calculate cost savings in categories described by TENNCARE.
- (b) Subrogation Recoveries. On a monthly basis, the CONTRACTOR shall report to TENNCARE the amount of any subrogation recoveries collected outside the claims processing system received during the previous month.

3. Reporting Provider Payment Issues

- (a) The CONTRACTOR shall ensure that collection letters are sent to contracting providers which maintain an accounts-payable balance to the State greater than ninety (90) days. These notices shall be sent within five (5) business days of becoming ninety (90) days old. The Contractor shall provide TENNCARE with a monthly report of notices that have been sent. Reports are due monthly within ten (10) business days after the end of the month.

Failure to send the notices as scheduled and/or report mailing to TENNCARE may result in liquidated damages as described in Section 4-8 of this Agreement.

- (b) The Contractor shall provide TENNCARE a report detailing all checks remitted to contracted providers on behalf of the State which remain outstanding (which have not been cashed) greater than ninety (90) days. Reports are due monthly within fifteen (15) business days after the end of the month.

Failure to report outstanding checks to TENNCARE as described above may result in liquidated damages as described in Section 4-8 of this Agreement.

23. Section 2-10.13 shall be amended by adding two new Sections 2-10.13.7 and 8 which shall read as follows:

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7. Disease Management Evaluation

Annually, on July 1st, the MCO will report to the Bureau regarding the following:

- (a) Performance measured against at least two important aspects of the clinical practice guidelines associated with each DM program;
- (b) The rate of emergency department utilization and inpatient hospitalization for members with diabetes, asthma and congestive heart failure (rate calculations must be shown);
- (c) Neonatal Intensive Care Unit (NICU) days for births associated with members enrolled in the Maternity Management Program;
- (d) HEDIS measures related to any of the four DM projects;
- (e) Any other performance measure associated with any of the four DM programs that the MCO has chosen to track;
- (f) The active participation rates (as defined by NCQA) and the number of individuals participating in each level or stratification of each of the DM programs; and
- (g) the total number of active enrollees having one or more of the diagnosis codes (ICD-9 Codes) relating to each of the required disease management programs.

8. Outlier Reporting

The CONTRACTOR shall analyze outlier data and report back to TENNCARE their findings. The CONTRACTOR shall assess the prescribing practices of all contracted providers and report back to the Bureau regarding their findings. The report will either provide assurance that the prescriber appears to be practicing their specialty in accordance with acceptable standards of care or will provide a plan to address any identified concern. At a minimum, TENNCARE shall provide the CONTRACTOR a semiannual report listing TennCare providers who appear to be outliers with regard to the numbers and percentages of narcotic prescriptions they write. All such reports shall be due back to TENNCARE within thirty (30) calendar days of the date that TENNCARE provides the CONTRACTOR with the request, unless TENNCARE's request provides for a longer response time.

24. Section 2-12 shall be deleted and replaced in its entirety so that the amended Section 2-12 shall read as follows:

2-12. Availability of Records

- 2-12.a. The CONTRACTOR shall insure within its own organization and pursuant to any agreement the CONTRACTOR may have with any other providers of service, including, but not limited to providers, subcontractors or any person or entity receiving monies directly or indirectly by or through TennCare, that TENNCARE representatives and authorized federal, state and Comptroller personnel, including, but not limited to TENNCARE, the Office of the Inspector General (OIG), the Medicaid Fraud Control Unit (MFCU), the Department of Health and Human Services, Office of Inspector General (HHS OIG) and the Department of Justice (DOJ), and any other duly authorized state or federal agency shall have immediate and complete access to all records pertaining to the medical care or services provided to TennCare enrollees.
- 2-12.b. The CONTRACTOR and its subcontractors and any providers of service, including, but not limited to providers or any person or entity receiving monies directly or indirectly by or through TennCare shall make all records (including but not limited to, financial and medical records) available at the CONTRACTOR's and/or the subcontractor's expense for administrative, civil and/or criminal review, audit, evaluation, inspection, investigation and/or prosecution by authorized federal, state, and Comptroller of Treasury personnel, including representatives from the OIG, the MFCU, DOJ and the HHS OIG, TENNCARE or any duly authorized state or federal agency. Access will be either through on-

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site review of records or through the mail at the government agency's discretion and during normal business hours, unless there are exigent circumstances, in which case access will be at any time. All records to be sent by mail will be sent to TENNCARE within twenty (20) working days of request unless otherwise specified by TENNCARE or TennCare rules and regulations. Requested records shall be provided at no expense to TENNCARE, authorized federal, state, and Comptroller of Treasury personnel, including representatives from the OIG, the MFCU, DOJ and the HHS OIG, or any duly authorized state or federal agency. Records related to appeals shall be forwarded within the time frames specified in the appeal process portion of this Contract. Such requests made by TENNCARE shall not be unreasonable.

The CONTRACTOR and any of its subcontractors, providers or any entity or person directly or indirectly receiving monies originating from TennCare, shall make all records, including, but not limited to, financial, administrative and medical records available to any duly authorized government agency, including but not limited to TENNCARE, OIG, MFCU, HHS OIG and DOJ, upon any authorized government agency's request. Any authorized government agency, including but not limited to OIG, MFCU, HHS OIG and DOJ, may use these records to carry out their authorized duties, reviews, audits, administrative, civil and/or criminal investigations and/or prosecutions.

2-12.c. The CONTRACTOR, any CONTRACTOR's management company and any CONTRACTOR's claims processing subcontractor shall cooperate with the State, or any of the State's contractors and agents, including, but not limited to TENNCARE, OIG, MFCU, DOJ and the HHS OIG, and the Office of the Comptroller, and any duly authorized governmental agency, during the course of any claims processing, financial or operational examinations or during any administrative, civil or criminal investigation, hearing or prosecution. This cooperation shall include, but shall not be limited to the following:

2-12.c.1. Providing full cooperation and direct and unrestricted access to facilities, information, and staff, including facilities, information and staff of any management company or sub-contractor, to the State or any of the State's contractors and agents, which includes, but is not limited to TENNCARE, OIG, MFCU, DOJ and the HHS OIG, and the Office of the Comptroller and any duly authorized governmental agency..

2-12.c.2. Maintaining full cooperation and open authority for claims processing systems access and mailroom visits by TDCI or designated representatives or any authorized entity of the state or federal government, and to cooperate fully with detail claims testing for claims processing system compliance.

2-12.c.3. Allowing for periodic review to ensure that all discounts, special pricing considerations and financial incentives have accrued to the State and that all costs have been incurred in accordance with this Contract, including the requirement that provider reimbursement rates, reimbursement policies/procedures, medical management policies and procedures and Subcontractor arrangements remain in effect as they existed on April 16, 2002, as specified in Section 2-9. The CONTRACTOR shall provide the auditor access to all information necessary to perform the examination.

2-12.c.4. The CONTRACTOR shall cooperate fully with audits the State may conduct of medical management to include clinical processes and outcomes, internal audits, provider networks, and any other aspect of the program the State deems appropriate. The State may select any qualified persons, or organization to conduct the audits.

25. Section 2-13 shall be deleted and replaced in its entirety so that the amended Section 2-13 shall read as follows:

2-13. Audit Requirements

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The CONTRACTOR and its providers, subcontractors and other entities receiving monies originating by or through TennCare shall maintain books, records, documents, and other evidence pertaining to services rendered, equipment, staff, financial records, medical records, and the administrative costs and expenses incurred pursuant to this Contract as well as medical information relating to the individual enrollees as required for the purposes of audit, or administrative, civil and/or criminal investigations and/or prosecution or for the purposes of complying with the requirements set forth in Section 1-5 of this Contract. Records other than medical records may be kept in an original paper state or preserved on micromedia or electronic format. Medical records shall be maintained in their original form or may be converted to electronic format as long as the records are readable and/or legible. These records, books, documents, etc., shall be available for any authorized federal, state, including, but not limited to TENNCARE, OIG, MFCU, DOJ and the HHS OIG, and Comptroller personnel during the Contract period and five (5) years thereafter, unless an audit, administrative, civil or criminal investigation or prosecution is in progress or audit findings or administrative, civil or criminal investigations or prosecutions are yet unresolved in which case records shall be kept until all tasks or proceedings are completed. During the Contract period, these records shall be available at the CONTRACTOR's chosen location in Tennessee subject to the approval of TENNCARE. If the records need to be sent to TENNCARE, the CONTRACTOR shall bear the expense of delivery. Prior approval of the disposition of CONTRACTOR, subcontractor or provider records must be requested and approved by TENNCARE.

26. Section 2-18 shall be deleted and replaced in its entirety so that the amended Section 2-18 shall read as follows:

2-18. Provider Agreements

The CONTRACTOR shall provide or assure the provision of all covered services specified in this Contract. The CONTRACTOR may provide these services directly or may enter into agreements with providers and provider subcontracting entities or organizations who will provide services to the enrollees in exchange for payment by the CONTRACTOR for services rendered.

The CONTRACTOR shall not execute provider agreements with providers who have been excluded from participation in the Medicare, Medicaid, and/or S-Chip programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with the TENNCARE program.

Except for agreements described herein, provider agreements do not require prior approval by TENNCARE before taking effect. Only those provider agreements described below shall require prior approval by TENNCARE: any revision to reimbursement rate and/or methodology, all new or revised facility agreements, and all agreements with providers whose contract status changed from contracted to non-contracted then back to contracted with an increase in reimbursement from the prior agreement. All single case agreements shall be reported to TENNCARE; however, prior approval will not be required unless TENNCARE determines, upon review of said reports, that it appears case agreements are being used to circumvent the "new contract review and approval process". All template provider agreements and revisions thereto must be approved in advance by the TennCare Division, Department of Commerce and Insurance in accordance with statutes regarding the approval of an HMOs certificate of authority (COA) and any material modifications thereof.

All provider agreements executed by the CONTRACTOR, and all provider agreements executed by subcontracting entities or organizations, pursuant to this Section shall, at a minimum, meet the following requirement: (No other terms or conditions agreed to by the CONTRACTOR and provider shall negate or supersede the following requirements.)

- 2-18. a. Be in writing. All new provider agreements and existing provider agreements as they are renewed, must include a signature page which contains CONTRACTOR and provider names which are typed or legibly written, provider company with titles, and dated signatures of all appropriate parties.

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- 2-18. b. Specify the effective dates of the provider agreement;
- 2-18. c. Specify in the provider agreement that the provider agreement and its attachments contain all the terms and conditions agreed upon by the parties;
- 2-18. d. Assure that the provider shall not enter into any subsequent agreements or subcontracts for any of the work contemplated under the provider agreement without approval of the CONTRACTOR;
- 2-18. e. Identify the population covered by the provider agreement;
- 2-18. f. Specify that the provider may not refuse to provide covered medically necessary or covered preventive services to a child under the age of twenty-one (21) or a TennCare Medicaid patient under this Contract for non-medical reasons. The CONTRACTOR may require that a TennCare Standard adult pay applicable TennCare cost share responsibilities prior to receiving non-emergency services. However, the provider shall not be required to accept or continue treatment of a patient with whom the provider feels he/she cannot establish and/or maintain a professional relationship;
- 2-18. g. Specify the functions and/or services to be provided by the provider and assure that the functions and/or services to be provided are within the scope of his/her professional/technical practice;
- 2-18. h. Specify the amount, duration and scope of services to be provided by the provider and inform provider of TennCare non-covered services as described in Section 2-5 of this Contract and the TennCare rules and regulations at 1200-13-13-.10 and 1200-13-14.10;
- 2-18. i. Provide that emergency services be rendered without the requirement of prior authorization of any kind;
- 2-18. j. Specify unreasonable delay in providing care to a pregnant member seeking prenatal care will be considered a material breach of the network provider's contract with the CONTRACTOR and include definition of unreasonable delay as described in Section 2-3.15.1.
- 2-18. k. If the provider performs laboratory services, the provider must meet all applicable requirements of the Clinical Laboratory Improvement Act (CLIA) of 1988 at such time that HCFA mandates the enforcement of the provisions of CLIA;
- 2-18. l. Require that an adequate record system be maintained and that all records be maintained for five (5) years from the close of the agreement or retained until all evaluations, audits, reviews or investigations or prosecutions are completed for recording enrollee services, servicing providers, charges, dates and all other commonly accepted information elements for services rendered to enrollees pursuant to the agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the provider agreement and administrative, civil or criminal investigations and prosecutions).

All agreements shall include a statement that as a condition of participation in TennCare, enrollees shall give the TENNCARE Bureau, TENNCARE, the Office of the Comptroller, and any health oversight agency, such as OIG, MFCU, HHS OIG, and DOJ, and any other authorized state or federal agency, access to their records. Said records shall be made available and furnished immediately upon request for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring as well as for administrative, civil and criminal investigations or prosecutions upon the request of an authorized representative of the CONTRACTOR, TENNCARE or authorized federal, state and Comptroller personnel, including, but not limited to, the OIG, the MFCU, the HHS OIG and the DOJ.

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Require that medical records requirements found in Section 2-9.7 be included in provider agreements and that medical records be maintained at site where medical services are rendered. Enrollees and their representatives shall be given access to the enrollees' medical records, to the extent and in the manner provided by T.C.A. Sections 63-2-101 and 63-2-102, and, subject to reasonable charges, be given copies thereof upon request. When a patient-provider relationship with a TennCare primary care provider ends and the enrollee requests that medical records be sent to a second TennCare provider who will be the enrollee's primary care case manager or gatekeeper, the first provider shall not charge the enrollee or the second provider for providing the medical records.

The provider agreement must contain the language described in Section 2-12 and 2-13 of this Contract;

- 2-18. m. Provide that TENNCARE, U.S. Department of Health and Human Services, and Office of Inspector General Comptroller, OIG, MFCU, and DOJ, as well as any authorized state or federal agency or entity shall have the right to evaluate through inspection, evaluation, review or request, whether announced or unannounced, or other means any records pertinent to this Contract including, but not limited to medical records, billing records, financial records, and/or any records related to services rendered, quality, appropriateness and timeliness of services and/or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution and such evaluation, inspection, review or request, and when performed or requested, shall be performed with the immediate cooperation of the provider. Upon request, the provider shall assist in such reviews including the provision of complete copies of medical records. Include a statement that HIPAA does not bar disclosure of PHI to health oversight agencies, including, but not limited to, OIG, MFCU, HHS OIG and DOJ. Provide that any authorized state or federal agency or entity, including, but not limited to TENNCARE, OIG, MFCU, HHS OIG, DOJ, Office of the Comptroller, may use these records and information for administrative, civil or criminal investigations and prosecutions;
- 2-18. n. Provide for monitoring, whether announced or unannounced, of services rendered to enrollees sponsored by the CONTRACTOR;
- 2-18. o. Whether announced or unannounced, provide for the participation and cooperation in any internal and external QM/QI, utilization review, peer review and appeal procedures established by the CONTRACTOR and/or TENNCARE;
- 2-18. p. Specify CONTRACTOR's responsibilities under its participation agreement, including but not limited to, provision of a copy of the member handbook whether via web site or otherwise and requirement that CONTRACTOR notice a provider of denied authorizations;
- 2-18. q. Specify that the CONTRACTOR shall monitor the quality of services delivered under the agreement and initiate corrective action where necessary to improve quality of care, in accordance with that level of medical care which is recognized as acceptable professional practice in the respective community in which the provider practices and/or the standards established by TENNCARE;
- 2-18. r. Require that the provider comply with corrective action plans initiated by the CONTRACTOR;
- 2-18. s. Provide for submission of all reports and clinical information required by the CONTRACTOR;
- 2-18. t. Provide the name and address of the official payee to whom payment shall be made;

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- 2-18. u. Make full disclosure of the method and amount of compensation or other consideration to be received from the CONTRACTOR;
- 2-18. v. Provide for prompt submission of information needed to make payment. Specify that a provider shall have at least, but no more than one hundred and twenty (120) calendar days from the date of rendering a health care service to file a claim with the CONTRACTOR except in situations regarding coordination of benefits or subrogation in which case the provider is pursuing payment from a third party or if an enrollee is enrolled in the plan with a retroactive eligibility date. In situations of third party benefits, the maximum time frames for filing a claim shall begin on the date that the third party documented resolution of the claim. In situations of enrollment in the plan with a retroactive eligibility date, the minimum and maximum time frames for filing a claim shall begin on the date that the CONTRACTOR receives notification from TENNCARE of the enrollee's eligibility;
- 2-18. w. Provide for payment to the provider upon receipt of a clean claim properly submitted by the provider within the required time frames as specified in T.C.A. 56-32-226 and Section 2-9.11. of this Contract;
- 2-18. x. Specify the provider shall accept payment or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payor) plus the amount of any applicable TennCare cost sharing responsibilities, as payment in full for covered services provided and shall not solicit or accept any surety or guarantee of payment from the enrollee in excess of the amount of applicable TennCare cost sharing responsibilities. Enrollee shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the patient being served;
- 2-18. y. For those agreements where the provider is compensated via a capitation arrangement, language which requires that, if provider becomes aware for any reason that s/he is not entitled to a capitation payment for a particular enrollee (a patient dies, for example), the provider shall immediately notify both the CONTRACTOR and TENNCARE by certified mail, return receipt requested. If such notification is not made within thirty days of the provider's knowledge, s/he may be subject to the sanctions set forth elsewhere in this Contract;
- 2-18. z. Require the provider to comply with fraud and abuse requirements described in Section 2-9.13 of this Contract;
- 2-18. aa. Require the provider to secure all necessary liability and malpractice insurance coverage as is necessary to adequately protect the Plan's enrollees and the CONTRACTOR under the agreement. The provider shall provide such insurance coverage at all times during the agreement and upon execution of the provider agreement furnish the CONTRACTOR with written verification of the existence of such coverage;
- 2-18. bb. Specify both the CONTRACTOR and the provider agree to recognize and abide by all state and federal laws, regulations and guidelines applicable to the health plan. Provide that the agreement incorporates by reference all applicable federal and state laws, TennCare rules and regulations or court orders, and revisions of such laws or regulations shall automatically be incorporated into the agreement, as they become effective. In the event that changes in the agreement as a result of revisions and applicable federal or state law materially affect the position of either party, the CONTRACTOR and provider agree to negotiate such further amendments as may be necessary to correct any inequities;
- 2-18. cc. Specify procedures and criteria for any alterations, variations, modifications, waivers, extension of the agreement termination date, or early termination of the agreement and specify the terms of such change. If provision does not require amendments be valid only when reduced to writing,

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duly signed and attached to the original of the agreement, then the terms must include provisions allowing at least thirty (30) days to give notice of rejection and requiring that receipt of notification of amendments be documented (e.g., Certified Mail, facsimile, hand-delivered receipt, etc);

- 2-18. dd. Specify that both parties recognize that in the event of termination of this Contract between the CONTRACTOR and TENNCARE for any of the reasons described in Section 6-2 of this Contract, the provider shall immediately make available, to TENNCARE, or its designated representative, in a usable form, any or all records, whether medical or financial, related to the provider's activities undertaken pursuant to the MCO/provider agreement. The provision of such records shall be at no expense to TENNCARE;
- 2-18. ee. Specify that the TennCare Provider Independent Review of Disputed Claims process shall be available to providers to resolve non-emergency claims denied in whole or in part by the MCO as provided at T.C.A. 56-32-226(b).
- 2-18. ff. Include a conflict of interest clause as stated in Section 6-7, Gratuities clause as stated in 6-11 and Lobbying clause as stated in 6-12 of this Contract between the CONTRACTOR and TENNCARE;
- 2-18. gg. Specify that at all times during the term of the agreement, the provider shall indemnify and hold TENNCARE harmless from all claims, losses, or suits relating to activities undertaken pursuant to the Contract between TENNCARE and the MCO. This indemnification may be accomplished by incorporating Section 6-20 of the TENNCARE/MCO Contract in its entirety in the provider agreement or by use of other language developed by the MCO and approved by TENNCARE.
- 2-18. hh. Require safeguarding of information about enrollees according to applicable state and federal laws and regulations and as described in Section 6-22 of this Contract;
- 2-18. ii. Specify the extent to which any savings or loss realized by the plan shall be shared with the providers;
- 2-18. jj. Specify that the provider shall be required to accept TennCare reimbursement amounts for services provided under the agreement between the provider and CONTRACTOR to TennCare enrollees and shall not be required to accept TennCare reimbursement amounts for services provided to persons who are covered under another health plan operated or administered by the CONTRACTOR;
- 2-18. kk. Specify provider actions to improve patient safety and quality;
- 2-18. ll. Provide general and targeted education to providers regarding emergency appeals, including when an emergency appeal is appropriate, and procedures for providing written certification thereof, and specify that the provider will comply with the appeal process, including but not limited to the following:
 - 1. assisting an enrollee by providing appeal forms and contact information including the appropriate address for submitting appeals for state level review; and
 - 2. require in advance, that providers seek prior authorization, when they feel they cannot order a drug on the TennCare PDL as well as taking the initiative to seek prior authorization when contacted by an enrollee or pharmacy regarding denial of a pharmacy service due to system edits (i.e., therapeutic duplication, etc.)
- 2-18. mm. Specify any liquidated damages, sanctions or reductions in payment that the CONTRACTOR may assess on the provider for specific failures to comply with contractual and/or credentialing requirements. This shall include, but may not be limited to a provider's failure or refusal to

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respond to the CONTRACTOR's request for information, the request to provide medical records, credentialing information, etc., at the CONTRACTOR's discretion or a directive by TENNCARE, the CONTRACTOR shall impose financial penalties against the provider as appropriate.

- 2-18. nn. Require that the provider display notices of the enrollee's right to appeal adverse action affecting services in public areas of their facility(s) in accordance with TennCare rules and regulations, subsequent amendments, or any and all Court Orders. The CONTRACTOR shall ensure that providers have correct and adequate supply of public notices;
- 2-18. oo. All provider agreements must include language which informs providers of the package of benefits that EPSDT (TENnderCare) offers and which requires providers to make treatment decisions based upon children's individual medical and behavioral health needs. A listing of the EPSDT benefit package is contained in Attachment IX of this Contract. All provider agreements must contain language that references the EPSDT (TENnderCare) benefit package found in Attachment IX and the agreement shall either physically incorporate Attachment IX or include language to require that the attachment be furnished to the provider upon request. At the next renewal or amendment period of provider agreements, this Attachment IX shall be deleted and replaced by the new reference and items found in Section 2-3.16.8 of this Contract;
- 2-18. pp. All provider agreements must include a provision which states that providers are not permitted to encourage or suggest, in writing or verbally, that TennCare children be placed into state custody in order to receive medical or behavioral services covered by TennCare;
- 2-18. qq. Specify that in the event that TENNCARE deems the MCO unable to timely process and reimburse claims and requires the MCO to submit provider claims for reimbursement to an alternate claims processor to ensure timely reimbursement, the provider shall agree to accept reimbursement at the MCO's contracted reimbursement rate or the rate established by TENNCARE, whichever is greater;
- 2-18. rr. All primary care provider agreements shall specify that its network primary care providers shall submit all claims with a primary behavioral health diagnosis (ICD-9 CM 290.xx – 319.xx) and claims for the provision of behavioral health services within CPT code range 96150 through 96155 to the CONTRACTOR for payment; and
- 2-18. ss. Require that providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.
- 2-18. tt. Specify instruction that the provider have written procedures for the provision of language interpretation and translation services for any enrollee who needs such services, including but not limited to, enrollees with Limited English Proficiency.
- 2-18. uu. Require the provider to comply and submit to the CONTRACTOR disclosure of information in accordance with the requirements specified in 42 CFR, Part 455, Subpart B.
- 2-18. vv. Require that if any requirement in the provider agreement is determined by TENNCARE to conflict with the Contract between TENNCARE and the MCO, such requirement shall be null and void and all other provisions shall remain in full force and effect

The CONTRACTOR shall give TENNCARE and the Tennessee Department of Commerce and Insurance, TennCare Division, immediate notification in writing by Certified Mail of any administrative or legal action or complaint filed regarding any claim made against the CONTRACTOR by a provider or enrollee which is related to the CONTRACTOR's responsibilities under this Contract, including but not limited to notice of any arbitration proceedings instituted between a provider and the CONTRACTOR.

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The CONTRACTOR shall ensure that all tasks related to the provider agreement are performed in accordance with the terms of this Contract.

27. The renumbered 4-1.1.l shall be amended by deleting and replacing the last sentence so that the amended Section 4-1.1.l shall read as follows:
 1. Enrollees selected for enrollment in the CONTRACTOR's plan by the State in Groups 1, 2, 3, 5 and 6 shall have one (1) opportunity, anytime during the forty-five (45) day period immediately following enrollment, to request to change MCO plans. Enrollees in Group 6 shall only be able to request to change MCO plans during this period to the extent capacity is available in another MCO serving the region. Once the initial forty-five (45) day change period has expired, the enrollee shall remain a member of the CONTRACTOR's plan until the the following change period , an appeal to change is decided in favor of the enrollee based on hardship criteria, or until the enrollee loses eligibility for TennCare.
28. The renumbered Section 4-1.1.o shall be amended by deleting and replacing the words "choice ballots" with "change requests" so that the amended Section 4-1.1.o shall read as follows:
 - o. The CONTRACTOR or anyone acting on its behalf shall not submit enrollment applications or change requests on behalf of TennCare eligibles.
29. The opening paragraph in Section 4-1.2 shall be deleted and replaced in its entirety and shall read as follows:

The CONTRACTOR shall give a full written explanation of the MCO's plan to enrollees within thirty (30) calendar days after notification of their enrollment in the MCO or prior to enrollee's beginning effective date, including but not limited to a member handbook and an identification card as described in Section 2-6.2 of this Agreement. In addition to the information described above, this written explanation shall, at a minimum, also include:

30. Section 5-1 shall be amended by adding a new j which shall read as follows:

j. Pay-for-Performance Administrative Fee for Disease Management (DM)

Depending of the level of performance, the CONTRACTOR may earn up to \$0.12 pmpm in the form of a supplemental administrative fee for disease management. On February 15, 2006, the CONTRACTOR must submit its disease management program plans to TennCare for approval. For each of the 4 (maternity care, diabetes, asthma and congestive heart failure) required disease management programs, the disease management program plan must include:

1. A description of the program, including content and intent
2. A definition of the target population, including an explanation of how the population will be identified and enrolled in the program
3. A written description of the stratification levels including member criteria and intervention strategies specific to each level
4. The clinical practice guidelines that will serve as a foundation for the program
5. The total number of active enrollees having one or more diagnosis codes representative of the particular disease/condition, as of January 1, 2006. If the target population is smaller than this number, the total number of active enrollees in the target population.
6. Defined process and outcomes measurement, evaluation, and management.
7. An established routine reporting/feedback loop (may include communication with patient, physician, MCO and ancillary providers, and practice profiling).

On July 1, 2006, the CONTRACTOR will be eligible for an additional \$0.03 pmpm, applied to member months from the period of July 1, 2005 to June 30, 2006, if their HEDIS 2006 HbA1c testing rate is at or

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above the 50th percentile for Medicaid HEDIS 2005, as reported by NCQA. In addition, on July 1, 2006, the CONTRACTOR will be eligible for an additional \$0.03 pmpm, applied to member months from the period of July 1, 2005 to June 30, 2006, if their HEDIS 2006 Prenatal Care rate is at or above the 75th percentile for Medicaid HEDIS 2005, as reported by NCQA.

On December 31, 2006, the CONTRACTOR will report the following ED utilization data to TENNCARE:

1. Emergency department visits with a diagnosis of asthma divided by total number of enrollees in the MCO with a diagnosis of asthma, multiplied by 1000 for the time periods July 1 – September 30 in calendar year 2005 and in calendar year 2006.
2. Emergency department visits with a diagnosis of congestive heart failure divided by total number of enrollees in the MCO with a diagnosis of congestive heart failure, multiplied by 1000 for the time periods July 1 – September 30 in calendar year 2005 and in calendar year 2006.

Emergency Department visits shall include all ER visits even if the visit results in a 23 Hour Observation or an inpatient stay. Include Emergency Department visits whether or not an actual payment to the provider was made for the services.

The CONTRACTOR will be eligible for an additional \$0.03 pmpm, applied to member months from the period of January 1, 2006 to December 31, 2006, if the ED visit rate per 1000 for asthma has decreased by at least 5% from 2005. Similarly, the CONTRACTOR will be eligible for an additional \$0.03 pmpm, applied to member months from the period of January 1, 2006 to December 31, 2006, if the ED visit rate per 1000 for congestive heart failure has decreased by at least 5% from 2005.

Beginning on July 1, 2007, the supplemental administrative fee will be referred to as a Quality Incentive and will be based on HEDIS, CAHPS and/or utilization criteria specified by TennCare and assessed annually. The CONTRACTOR will be advised of the specific methodology that will be used for the July 1, 2007 supplemental fee determination, by September 1, 2006.

31. Section 5-3.a shall be deleted and replaced in its entirety so that the amended Section 5-3.a shall read as follows:

- a. Medical Services Payments. The CONTRACTOR shall prepare checks for payment on a periodic basis. The CONTRACTOR shall notify the State of the amount to be paid in a mutually acceptable form and substance at least 72 hours in advance of distribution of provider checks. The amount to be paid shall be reduced by the amount of third party recoveries captured in the claims processing system. The State shall release funds in the amount to be paid to providers to the CONTRACTOR. Funds shall be released within 72 hours of receipt of notice. In turn, the CONTRACTOR shall release payments to providers within 24 hours of receipt of funds from the State and provide TENNCARE with a check register or similar document that is generated from the managed care claims processing system supporting the release of these payments by no later than seven (7) calendar days after the CONTRACTOR's request of the funds.

For each request related to payments to providers through the CONTRACTOR's claims processing system, the CONTRACTOR shall provide a claims data extract in a format and media described by TENNCARE to support the payments released to providers. The CONTRACTOR should provide a reconciliation for the total paid amounts between the funds released for payment to providers, the supporting claims data extract, and the encounter data submissions for the relevant adjudication cycle. The reconciliation should be submitted within seven (7) days of the claims data extract.

Upon notification by TENNCARE, funds released to the CONTRACTOR for purposes of provider payments shall be made based on the CONTRACTOR's encounter data. TENNCARE

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shall implement this process by initially making payments based on all encounters and providing the CONTRACTOR an error report of unacceptable encounter records. The final phase of implementation shall result in TENNCARE releasing funds based on clean encounters only. Once TENNCARE releases funds based solely on clean encounter data, the CONTRACTOR will no longer be required to submit the claims data extract. The reconciliation and check register must continue to be submitted on a weekly basis for the previous weeks check release.

The CONTRACTOR shall pursue and report on providers which maintain an accounts-payable balance or maintain outstanding checks in accordance with Section 2-10.1 of this Agreement.

32. Section 5-4.a shall be deleted and replaced in its entirety so that the amended Sections 5-4.a shall read as follows:
- a. Except where required by the Contractor's Contract with TennCare or by applicable federal or state law, rule or regulation, the CONTRACTOR shall not make payment for the cost of any medical care provided prior to the effective date of eligibility or after the termination date in the CONTRACTOR's plan. The CONTRACTOR shall make payment for the cost of any covered services obtained on or after 12:01 a.m. on the effective date of eligibility in the CONTRACTOR's plan.
33. Section 6-7 shall be amended by adding the words "in writing" in subpart (2) and by deleting and replacing the word "Agreement" with the word "Contract" so that the amended Section 6-7 shall read as follows:

6-7. Conflict of Interest

The CONTRACTOR warrants that during the term of this Contract no payments shall be paid to the following:

- (1) any State or federal officer, including but not limited to
 - a. a member of the State Legislature, or
 - b. a member of Congress, or
 - c. any immediate family member of any State or federal officer; or
- (2) any State or federal employee or any immediate family member of a State or federal employee unless otherwise authorized in writing by the Commissioner, Tennessee Department of Finance and Administration. Immediate family members may be exempted if State or federal officer or employee discloses such relationship to TENNCARE and the TennCare Oversight Committee. The applicability of this section includes, but is not limited to, any and all arrangements and/or agreements, written or verbal, that result in the CONTRACTOR making a payment or providing a gift in exchange for services or supplies.

The CONTRACTOR must certify annually by filing a TennCare Disclosure of Lobbying Activities Form (Attachment II) with TENNCARE and the TennCare Oversight Committee that the CONTRACTOR is in compliance with all state and federal laws relating to conflicts of interest and lobbying, having made diligent inquiry of all subcontractors and/or persons receiving payment or gifts from CONTRACTOR pursuant to this Contract. This form must be signed by the Chief Executive Officer of the CONTRACTOR or his/her designee and must be received by TENNCARE and the TennCare Oversight Committee no later than December 31 of each year beginning with December 31, 2005. The certification must include any and all subcontractors, vendors, agents, providers, representatives and others with verbal or written agreements with the CONTRACTOR which receive reimbursement through this Contract from the CONTRACTOR. The Chief Executive Officer acknowledges that he/she is responsible for ensuring that internal controls are in place to prevent and detect potential conflicts of interest and that due diligence

Amendment 12 (cont.)

was performed before providing certification of compliance. Any changes by the CONTRACTOR relating to the disclosure of conflicts of interest or lobbying must be disclosed to TENNCARE within five (5) business days of the date of the change. (See Section 4-12 for definitions of lobbying activities)

This Contract may be terminated by TENNCARE if it is determined that the CONTRACTOR, its agents or employees offered or gave gratuities of any kind to any official, employee or immediate family member of an employee of the State of Tennessee, including a member of the State legislature. This Contract may be terminated by TENNCARE if it is determined that gratuities of any kind were offered to or received by any of the aforementioned officials or employees from the CONTRACTOR, his agent, or employees.

Failure to comply with the provisions required herein shall result in liquidated damages in the amount of one-hundred ten percent (110%) of the total amount of compensation that was paid inappropriately and may be considered a breach of this Contract as described in Section 4-2. and subject to termination of this Contract.

The CONTRACTOR shall be responsible for maintaining adequate internal controls to detect and prevent conflicts of interest from occurring at all levels of the organization and include the substance of this clause in all agreements, subcontracts, provider agreements, and any and all agreements that result from this Contract between CONTRACTOR and TENNCARE.

- 34. Section 6-8 shall be amended by deleting Program Issue A.7 and renumbering the remaining Issues accordingly.
- 35. Section 6-8.b.2 shall be amended by adding four new Program Issues which shall read as follows:

B.10	Failure to obtain approval of Marketing Materials.	\$500 per day for each calendar day that TENNCARE determines the CONTRACTOR has provided enrollee material that has not been approved by TENNCARE.
B.11	Failure to comply with Marketing timeframes for providing Member Handbooks, I.D. cards, Provider Directories, and Newsletters.	\$5000 for each occurrence.
B.12	Failure to achieve and/or maintain financial reserves in accordance with TCA	\$500 per calendar day for each day that financial requirements have not been met.
B.13	Failure to comply with fraud and abuse provisions as described in Section 2-9.13 of this Contract.	\$500 per calendar day for each day that the CONTRACTOR does not comply with fraud and abuse provisions described in Section 2-9.13 of this Contract.
B.14	Failure to send collection letters to providers and report mailing to TENNCARE as described in 2-10.5.3(a) of this Agreement.	\$100 per provider notice per month.

Amendment 12 (cont.)

B.15	Failure to send a detailed report of outstanding provider checks as described in 2-10.5.3(b) of this Agreement.	\$500 per week for each week that report is late.
B.16	Failure to require and assure compliance with Ownership and Disclosure requirements.	\$5000 per provider application for each application that is signed by a provider that does not request or contain complete and satisfactory disclosure of the requirements outlined in 42 CFR 455, Subpart B.

36. Section 6-28 shall be amended by deleting “2005” and replacing it with “2006” in the third sentence so that the amended Section 6-28 shall read as follows:

6-27 Contract Term of The Agreement

This Agreement and its incorporated attachments, if any, as well as all Amendments to this Agreement, contain all of the terms and conditions agreed upon by the parties, and when executed by all parties, supersedes any prior agreements. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall be in effect from July 1, 2001, subject to approval by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The term of this Agreement shall expire on December 31, 2006. At the mutual agreement of TennCare and the CONTRACTOR, this CONTRACT shall be renewable for an additional twelve month period.

Notwithstanding any provision herein to the contrary, the State may terminate this Agreement if the waiver governing TennCare is terminated. The documents referenced in the Agreement are on file with the CONTRACTOR and with TENNCARE and the CONTRACTOR is aware of their content. No other agreement, oral or otherwise regarding the subject matter of this Agreement, shall be deemed to exist or to bind any of the parties hereto.

37. Section 7-3 shall be amended by deleting and replacing 7-3.i and adding a new 7-3.n so that the amended Sections 7-3.i and n shall read as follows:
- i. Alternative method of lock-in restriction procedures.;
 - n. Any changes to provider or subcontractor reimbursement rates and reimbursement methodologies and all inpatient facility agreements.
38. The current Attachment IX shall be deleted and replaced in its entirety and shall be attached to the end of this Amendment.
39. The current Attachment XII, Exhibit H.1 shall be deleted and replaced and shall be attached to the end of this Amendment.

ATTACHMENT IX - FORMS FOR REPORTING FRAUD AND ABUSE

TENNESSEE BUREAU OF INVESTIGATION
MEDICAID FRAUD CONTROL UNIT
FRAUD ALLEGATION REFERRAL FORM

DATE: _____

TO (circle recipient): SAC Bob Schlafly [fax (615) 744-4659]
ASAC Stephen Phelps [fax (731) 668-9769]
ASAC Norman Tidwell [fax (615) 744-4659]

FROM: _____ (TennCare Contractor)

Contact Person: _____
Telephone: _____
E-Mail: _____

SUBJECT NAME: _____ d/b/a _____
SUBJECT ADDRESS: _____

PROVIDER NUMBER(S): _____

SUMMARY OF COMPLAINT: _____

ADDITIONAL SUBJECT INFORMATION: _____

REPORT TENNCARE RECIPIENT FRAUD OR ABUSE

Amendment 12 (cont.)

Date:

Please complete as much information as possible.

Name of Recipient/Person you are Reporting recipient name or name of individual suspected of fraud

Other Names Used (if known) alias

Social Security Number (If known)

Date of Birth

Children's Name (if applicable) SSN, if known DOB, if known

Spouse's Name (if applicable) SSN, if known DOB, if known

Street Address physical address

Apartment #

City, State, Zip city state zip

Other Addresses Used

Home Phone Number area code

Work Phone Number (Please include) area code

Employer's Name

Employer's Address

Employer's Phone # area code

What is your complaint? (In your own words, explain the problem)describe suspected fraudulent behavior

Have you notified the Managed Care Contractor of this problem? Yes No

Who did you notify? (Please provide name and phone number, if known)name phone number dept/ business

Have you notified anyone else? No Yes name phone dept/ business

Requesting Drug Profile Yes No Have already received drug profile Yes No

If you are already working with a PID staff person, who?

*Please attach any records of proof that may be needed to complete the initial review.

OIG/CID Investigator: your name

Phone number

STATE OF TENNESSEE
OFFICE OF TENNCARE INSPECTOR GENERAL
PO BOX 282368
NASHVILLE, TENNESSEE 37228

FRAUD TOLL FREE HOTLINE 1-800-433-3982 • FAX (615) 256-3852

E-Mail Address: www.tennessee.gov/tennicare (follow the prompts that read "Report Fraud Now")

SAMPLE GRID

MCO NAME: REPORTING PARTY: TELEPHONE #:							Reporting Period											
							QTR 1			QTR 2			QTR 3			QTR 4		
							(Please Indicate Reporting QTR above)											
QI Activity	Indicator	Scope	Objective	Bench- Mark	Goals	Responsible/Reporting Party	2006 Reporting Frequency											
							1st QTR			2nd QTR			3rd QTR			4th QTR		
							J	F	M	A	M	J	J	A	S	O	N	D
Administration	Approval of written QI Program Description, UM Program Description, Work Plans and QI Evaluation	MCO care delivery system	To assure approval of the QI Program Description, UM Program Description, QI Work Plan and QI/UM Evaluation	N/A	N/A					X								
	Quarterly Report to the MCO Governing Body and TENNCARE	MCO care delivery system	To review key indicators that monitor the delivery of quality care and services by the MCO (HEDIS and CAHPS data to be reported in July)	N/A	N/A		X			X				X			X	
	MCO Committee Meeting Schedule	MCO care delivery system	To assure MCO committee meetings (QI, Credentialing, UM, etc.) occur as scheduled and are documented appropriately.	N/A	N/A		X			X				X			X	
	GEO Access Analysis	PCP and MCO identified specialists	To evaluate the accessibility of providers for existing members	N/A	N/A		X			X				X			X	
	MCO Strategic Plan	MCO care delivery system	To provide a vehicle by which to monitor the completion of major business objectives, milestones, and barriers to success	N/A	N/A					X								

Amendment 12 (cont.)

MCO NAME: REPORTING PARTY: TELEPHONE #:							Reporting Period													
							QTR 1			QTR 2			QTR 3			QTR 4				
							(Please Indicate Reporting QTR above)													
QI Activity	Indicator	Scope	Objective	Bench-Mark	Goals	Responsible/Reporting Party	2006 Reporting Frequency													
							1st QTR			2nd QTR			3rd QTR			4th QTR				
							J	F	M	A	M	J	J	A	S	O	N	D		
Credentialing	Initial Credentialing	Prospective MCO providers	To complete initial credentialing process within the timeframes described in NCQA's Standards for Credentialing				X	X	X	X	X	X	X	X	X	X	X	X	X	
	Recredentialing	Existing MCO providers	To complete the recredentialing process within the timeframes described in NCQA's Standards for Recredentialing				X	X	X	X	X	X	X	X	X	X	X	X	X	
Population Analysis	Analysis of member population by sex, age, and product	MCO Membership	To evaluate MCO population mix	N/A	N/A													X		
Clinical	High-Volume Diagnoses by Inpatient, Outpatient, Facilities	MCO Membership	To evaluate high-volume diagnoses and MCO demographics in order to validate clinical indicators	N/A	N/A		X			X		X						X		
	High-Volume Procedures	MCO Membership	To detect trends in high volume procedures	N/A	N/A		X			X		X						X		
	Identification of High-Volume Specialists	Specialty Network	To ensure the availability of specialty care practitioners within the specialty network.	N/A	N/A					X										
	Medical Record Confidentiality and Documentation Review Program	Primary Care Provider	To assure documentation is in accordance with MCO standards				X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Offsite Assessment 1. Professional Appearance 2. Pharmaceutical Audit 3. Emergency Equipment 4. OSHA Compliance	Primary Care Providers, high-volume specialists	To assure a safe environment for members seeking care				X	X	X	X	X	X	X	X	X	X	X	X	X	X

Amendment 12 (cont.)

MCO NAME: REPORTING PARTY: TELEPHONE #:							Reporting Period															
							QTR 1			QTR 2			QTR 3			QTR 4						
							(Please Indicate Reporting QTR above)															
QI Activity	Indicator	Scope	Objective	Bench-Mark	Goals	Responsible/Reporting Party	2006 Reporting Frequency															
							1st QTR			2nd QTR			3rd QTR			4th QTR						
							J	F	M	A	M	J	J	A	S	O	N	D				
	Quality Indicators	MCO Membership	To monitor high-risk occurrence trends				X						X									
	Confirmed Quality Concerns	MCO Membership	To provide a vehicle by which to monitor the quality of care delivered by MCO providers and to develop individual and MCO Quality Improvement Strategies				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Clinical Practice Guidelines - Annual Approval of:	MCO Providers	To implement/update and measure compliance with MCO adopted Best Clinical Practice for the Clinical QI Activities								X											
	1										X											
	2										X											
	3										X											
	4										X											
	Clinical QIA I	Diabetes									X											
	Clinical QIA II	Maternity Management									X											
	Clinical QIA III										X											

Amendment 12 (cont.)

MCO NAME: REPORTING PARTY: TELEPHONE #:							Reporting Period											
							QTR 1			QTR 2			QTR 3			QTR 4		
QI Activity Indicator Scope Objective Bench-Mark Goals Responsible/Reporting Party							2006 Reporting Frequency											
							1st QTR			2nd QTR			3rd QTR			4th QTR		
							J	F	M	A	M	J	J	A	S	O	N	D
HEDIS Effectiveness of Care Measures	Childhood Immunization Status	Enrolled children 2 years of age	To determine the percentage of enrolled children 2 years of age who were appropriately immunized								X							
	Adolescent Immunization Status	Enrolled adolescents 13 years of age	To determine the percentage of enrolled adolescents 13 years of age who were appropriately immunized								X							
	Appropriate Treatment for Children With Upper Respiratory Infection	Enrolled children 3 months-18 years of age given a diagnosis of URI and were not dispensed an antibiotic on or three days after the episode date.	To determine the percentage of enrolled children 3 months-18 years of age who received appropriate treatment (those for whom an antibiotic was not prescribed).								X							
	Appropriate Testing for Children With Pharyngitis	Enrolled children 2-18 years of age who were diagnosed with pharyngitis, prescribed an antibiotic and received a group A streptococcus test for the episode.	To determine the percentage of enrolled children 2-18 years of age who were diagnosed with pharyngitis, and received appropriate treatment.								X							

Amendment 12 (cont.)

MCO NAME: REPORTING PARTY: TELEPHONE #:							Reporting Period															
							QTR 1			QTR 2			QTR 3			QTR 4						
QI Activity Indicator Scope Objective Bench-Mark Goals Responsible/Reporting Party							2006 Reporting Frequency															
							1st QTR			2nd QTR			3rd QTR			4th QTR						
							J	F	M	A	M	J	J	A	S	O	N	D				
	Inappropriate Antibiotic Treatment for Adults With Acute Bronchitis	Enrolled healthy adults 18-64 years of age with a diagnosis of acute bronchitis who were dispensed an antibiotic prescription on or within three days after the episode date.	To determine the percentage of enrolled healthy adults 18-64 years of age with a diagnosis of acute bronchitis who received appropriate treatment.								X											
	Breast Cancer Screening	Women 50-69 years of age	To determine the percentage of women 50-69 years of age who had a mammogram during the measurement year or the prior year.								X											
	Cervical Cancer Screening	Women 18-64 years of age	To determine the percentage of women 18-64 years of age who received one or more pap tests during the measurement year or the 2 prior years.								X											
	Chlamydia Screening in Women	Women 16-25 years of age	To determine the percentage of women 16-25 years of age who were identified as sexually active, who had at least one test for chlamydia during the measurement year.								X											

Amendment 12 (cont.)

MCO NAME: REPORTING PARTY: TELEPHONE #:							Reporting Period														
							QTR 1			QTR 2			QTR 3			QTR 4					
							(Please Indicate Reporting QTR above)														
							2006 Reporting Frequency														
QI Activity	Indicator	Scope	Objective	Bench-Mark	Goals	Responsible/Reporting Party	1st QTR			2nd QTR			3rd QTR			4th QTR					
							J	F	M	A	M	J	J	A	S	O	N	D			
	Controlling High Blood Pressure	Enrolled members 46-85 years of age who had a DX of HTN	To determine the percentage of enrolled members 46-85 years of age with a DX of HTN and whose BP was adequately controlled ($\leq 140/90$) during the measurement year.																		
	Beta Blocker Treatment after a Heart Attack	Enrolled members 35 years of age and older who were hospitalized and discharged alive from 1/1 to 12/24 of the measurement year with a DX of AMI and received an ambulatory Rx for beta blockers upon discharge.	To assess whether appropriate follow-up care has been rendered to members who suffer a heart attack																		

Amendment 12 (cont.)

MCO NAME: REPORTING PARTY: TELEPHONE #:							Reporting Period															
							QTR 1	QTR 2	QTR 3	QTR 4												
							(Please Indicate Reporting QTR above)															
QI Activity	Indicator	Scope	Objective	Bench-Mark	Goals	Responsible/Reporting Party	2006 Reporting Frequency															
							1st QTR			2nd QTR			3rd QTR			4th QTR						
							J	F	M	A	M	J	J	A	S	O	N	D				
	Annual Monitoring for Patients on Persistent Medication	Enrolled members 18 years of age and older who received at least 180 day supply of ambulatory medication therapy for the selected therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year.	To assess whether persistent users of medication receive timely monitoring to prevent potential harms associated with persistent use of these drugs.								X											

Amendment 12 (cont.)

MCO NAME: REPORTING PARTY: TELEPHONE #:							Reporting Period															
							QTR 1			QTR 2			QTR 3			QTR 4						
							(Please Indicate Reporting QTR above)															
QI Activity	Indicator	Scope	Objective	Bench-Mark	Goals	Responsible/Reporting Party	2006 Reporting Frequency															
							1st QTR			2nd QTR			3rd QTR			4th QTR						
							J	F	M	A	M	J	J	A	S	O	N	D				
	Medical Assistance with Smoking Cessation (survey measure)	Members 18 years of age and older who are current smokers who were seen by a MCO practitioner during the measurement year and received advice to quit smoking; cessation was recommended or discussed, strategies for cessation were recommended or discussed.	To assess different facets of medical assistance with smoking cessation.										X									
Disease Management	Disease Management Maternity Management	MCO Members with acute/chronic conditions	To identify members and actively intervene to assist both members and providers in managing chronic conditions, to improve the health status of the members				X				X			X						X		
	Disease Management Diabetes	MCO Members with chronic conditions	To identify members and actively intervene to assist both members and providers in managing chronic conditions, to improve the health status of the members				X				X			X						X		

Amendment 12 (cont.)

MCO NAME: REPORTING PARTY: TELEPHONE #:							Reporting Period											
							QTR 1			QTR 2			QTR 3			QTR 4		
							(Please Indicate Reporting QTR above)											
QI Activity	Indicator	Scope	Objective	Bench-Mark	Goals	Responsible/Reporting Party	2006 Reporting Frequency											
							1st QTR			2nd QTR			3rd QTR			4th QTR		
							J	F	M	A	M	J	J	A	S	O	N	D
	Disease Management Asthma	MCO Members with chronic conditions	To identify members and actively intervene to assist both members and providers in managing chronic conditions, to improve the health status of the members				X			X			X			X		
	Disease Management Congestive Heart Failure	MCO Members with chronic conditions	To identify members and actively intervene to assist both members and providers in managing chronic conditions, to improve the health status of the members				X			X			X			X		
Methodology	Inter-rater reliability	MCO nurse and physician reviewers	To assure high levels of reliability between nurse reviewers and physician reviewers in utilization and quality management							X								
UM	Prior Authorization Call Reporting 1. Call Answer Timeliness 2. Call Abandonment Rate	All attempts by provider/staff to access the prior auth line	To reduce average Call Answer Timeliness <30 seconds to get a live voice and the call abandon rate to < 5%		CAT: <30 Sec & CAB: <5%		X			X			X			X		
	Scientific medical technology review. Review is ongoing	New Technologies or new applications of established technologies and obsolete technologies	To provide a consistent, efficient systematic process for assessment of technology and a mechanism for annual re-review of existing assessments	N/A	N/A					X								

Amendment 12 (cont.)

MCO NAME: REPORTING PARTY: TELEPHONE #:							Reporting Period															
							QTR 1			QTR 2			QTR 3			QTR 4						
							(Please Indicate Reporting QTR above)															
QI Activity	Indicator	Scope	Objective	Bench-Mark	Goals	Responsible/Reporting Party	2006 Reporting Frequency															
							1st QTR			2nd QTR			3rd QTR			4th QTR						
							J	F	M	A	M	J	J	A	S	O	N	D				
	Under/over-utilization	Primary Care Physician, Specialty Care Physician, IP, ED, etc.	To identify potential under/over utilization trends within the participating provider network and to initiate appropriate actions when performance falls below established standards	N/A	N/A					X												
	UM Medical Necessity Criteria - Annual Approval	MCO membership	To provide a mechanism for updating the MCO's review of criteria on an annual basis	N/A	N/A					X												
Pharmacy	Controlled Substance Audit	Contracted providers	To identify potential adverse drug reactions and drug/drug interactions regarding controlled substance prescriptions; to intervene with PCPs and specialists on controlled substance prescribing patterns; and to intervene with members when appropriate (CM)				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Amendment 12 (cont.)

MCO NAME: REPORTING PARTY: TELEPHONE #:							Reporting Period																
							QTR 1			QTR 2			QTR 3			QTR 4							
							(Please Indicate Reporting QTR above)																
QI Activity	Indicator	Scope	Objective	Bench-Mark	Goals	Responsible/Reporting Party	2006 Reporting Frequency																
							1st QTR			2nd QTR			3rd QTR			4th QTR							
							J	F	M	A	M	J	J	A	S	O	N	D					
Service	Service QIA I																						
	Service QIA II																						
	Member Services Call Reporting 1. Call Answer Timeliness 2. Call Abandonment Rate	All attempts by callers to access Member Services	To reduce average Call Answer Timeliness <30 seconds to get a live voice and the call abandon rate to < 5%			CAT: <30 Sec & CAB: <5%		X							X							X	
	Average days to close: Inquires	Member Inquires	To monitor the timeliness of resolution (aging) of customer inquires				X				X				X							X	
	Appeal Overtum Rate	Medicaid appeals overturned by the MCO	To reduce the number of appeals overturned by the MCO through the identification and elimination of inappropriate denials				X				X				X							X	
	Top Three Reasons for Appeals	MCO members & network providers	To monitor the top reasons for member & provider appeals				X				X				X							X	
	Provider Appointment Availability Measure: 1. Initial Appointment Routine Health Assessment (3 weeks) 2. Urgent Problem (within 48 hours)	Primary Care Physician offices	Evaluate access to Primary Care network using MCO access standards												X								
	Provider Availability After Hours/Weekend	Primary Care Providers	Monitor member access to emergent care 24 hours/day				X				X				X							X	
	Wait Time not to exceed 45 minutes for non-urgent care	Primary Care Providers	To monitor member wait time in provider offices, not to exceed 45 minutes												X								

Amendment 12 (cont.)

MCO NAME: REPORTING PARTY: TELEPHONE #:							Reporting Period																	
							QTR 1			QTR 2			QTR 3			QTR 4								
							(Please Indicate Reporting QTR above)																	
QI Activity	Indicator	Scope	Objective	Bench-Mark	Goals	Responsible/Reporting Party	2006 Reporting Frequency																	
							1st QTR			2nd QTR			3rd QTR			4th QTR								
							J	F	M	A	M	J	J	A	S	O	N	D						
Satisfaction	Member Satisfaction Surveys (CAHPS 3.0H Adult Survey, CAHPS 3.0H Child Surey and Children with Chronic Conditions)	MCO Members	To measure longitudinal satisfaction rates to identify positive or negative trends; and opportunities for improvement.																					
	Provider Satisfaction Survey	Primary Care Providers	To measure provider's overall satisfaction with the MCO (prior auth process)																					
Delegation	Delegation	Contracted Provider	To ensure all MCO standards related to delegated functions are met				X				X					X						X		

Amendment 12 (cont.)

MCO NAME: REPORTING PARTY: TELEPHONE #:							Reporting Period											
							QTR 1			QTR 2			QTR 3			QTR 4		
							(Please Indicate Reporting QTR above)											
QI Activity	Indicator	Scope	Objective	Bench-Mark	Goals	Responsible/Reporting Party	2006 Reporting Frequency											
							1st QTR			2nd QTR			3rd QTR			4th QTR		
							J	F	M	A	M	J	J	A	S	O	N	D
Education	Educational Programs	MCO Members, Providers and MCO Associates	To promote opportunities to meet identified training/educational needs								X							
	Member handbook	MCO Members (Upon enrollment and annually thereafter) and Providers (upon initial credentialing and as changes occur)	To provide members and providers with key information including, but not limited to their rights, responsibilities, access to care and how to file an appeal.								X							
	Quarterly Member Newsletters	MCO Members and Providers	To provide members and providers with updated MCO information, promote healthy lifestyles, encourage appropriate utilization of preventive care and screenings (including EPSDT).				X			X			X			X		
	Quarterly Provider Newsletters	MCO Contracted Providers	To update providers on MCO initiatives, communicate pertinent information to contracted providers.				X			X			X			X		

Amendment 12 (cont.)

All of the provisions of the original Contract not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective January 1, 2006 or as of the date it is approved by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

VOLUNTEER STATE HEALTH PLAN, INC.

BY: M. D. Goetz, Jr.
M. D. Goetz, Jr.
Commissioner

BY: Ronald E. Harr
Ronald E. Harr
President and Chief Executive Officer

DATE: 12/28/2005

DATE: Dec 22, 2005

APPROVED BY:

APPROVED BY:

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

**STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY**

BY: M. D. Goetz, Jr.
M. D. Goetz, Jr.
Commissioner

BY: John G. Morgan
John G. Morgan
Comptroller

DATE: _____

DATE: 1/3/06

CONTRACT SUMMARY SHEET

RFS Number:	318.66-026	Contract Number:	FA-02-14632-11
State Agency:	Department of Finance and Administration	Division:	Bureau of TennCare

Contractor	Contract Identification Number
VSHP (TennCare Select)	<input type="checkbox"/> V- <input type="checkbox"/> C-

Service Description

Managed Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medicaid Population

Contract Begin Date	Contract End Date
7/1/2001	12/31/2005

Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66	532	134	11	<input type="checkbox"/> STARS		
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)	
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$	18,599,868.48
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$	33,079,942.80
2004	\$ 25,125,990.72	\$ 38,364,165.90			\$	63,490,156.62
2005	\$ 58,007,447.00	\$ 58,007,447.00			\$	116,014,894.00
2006	\$ 27,667,750.00	\$ 27,667,750.00			\$	55,335,500.00
Total:	\$ 133,342,248.35	\$ 153,178,113.55			\$	286,520,361.90

CFDA# 93.778 Title XIX Dept. of Health & Human Svcs.	Check the box ONLY if the answer is YES:
State Fiscal Contract	<input type="checkbox"/> Is the Contractor a SUBRECIPIENT? (per OMB A-133)
Name: Dean Daniel	<input type="checkbox"/> Is the Contractor a Vendor? (per OMB A-133)
Address: 729 Church Street	<input type="checkbox"/> Is the Fiscal Year Funding STRICTLY LIMITED?
Phone: Nashville, TN (615)532-1362	<input type="checkbox"/> Is the Contractor on STARS?
Procuring Agency Budget Officer Approval Signature	<input type="checkbox"/> Is the Contractor's FORM W-9 ATTACHED?
Scott Pierce	<input type="checkbox"/> Is the Contractor's Form W-9 Filed with Accounts?

COMPLETE FOR ALL AMENDMENTS (only)		
	Base Contract & Prior Amendments	This Amendment ONLY
CONTRACT END DATE:	12/31/2005	
FY: 2002	\$ 18,599,868.48	
FY: 2003	\$ 33,079,942.80	
FY: 2004	\$ 63,490,156.62	
FY: 2005	\$ 116,014,894.00	
FY: 2006	\$ 55,335,500.00	
Total:	\$ 286,520,361.90	

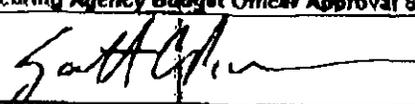
Funding Certification

Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.

RECEIVED

JUL 5 - 2005

MANAGEMENT SERVICES

CONTRACT SUMMARY SHEET						
RFS Number: 318.66-026		Contract Number: FA-02-14632-11				
State Agency: Department of Finance and Administration		Division: Bureau of TennCare				
Contractor			Contract Identification Number			
VSHP (TennCare Select)			<input type="checkbox"/> V- <input type="checkbox"/> C-			
Service Description						
Managed Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medicaid Population						
Contract Begin Date			Contract End Date			
7/1/2001			12/31/2005			
Allocation Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66	532	134	11	<input type="checkbox"/> STARS		
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)	
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$ 18,599,868.48	
2003	\$ 16,785,123.40	\$ 17,294,819.40			\$ 33,079,942.80	
2004	\$ 25,125,990.72	\$ 38,364,165.90			\$ 63,490,156.62	
2005	\$ 58,007,447.00	\$ 58,007,447.00			\$ 116,014,894.00	
2006	\$ 27,667,750.00	\$ 27,667,750.00			\$ 55,335,500.00	
Total:	\$ 133,342,248.35	\$ 163,178,113.55			\$ 286,520,361.90	
CFDA#	93.778 Title XIX Dept. of Health & Human Svcs.			Check the box ONLY if the answer is YES:		
State Fiscal Contract				Is the Contractor a SUBRECIPIENT? (per OMB A-133)		
Name: Dean Daniel				Is the Contractor a Vendor? (per OMB A-133)		
Address: 729 Church Street				Is the Fiscal Year Funding STRICTLY LIMITED?		
Phone: Nashville, TN (615)532-1352				Is the Contractor on STARS?		
Procuring Agency Budget Officer Approval Signature				Is the Contractor's FORM W-9 ATTACHED?		
Scott Pierce 				Is the Contractor's Form W-9 Filed with Accounts?		
COMPLETE FOR ALL AMENDMENTS (only)				Funding Certification		
CONTRACT END DATE:		Base Contract & Prior Amendments	This Amendment ONLY			
		12/31/2005				
FY: 2002		\$ 18,599,868.48				
FY: 2003		\$ 33,079,942.80				
FY: 2004		\$ 63,490,156.62				
FY: 2005		\$ 116,014,894.00				
FY: 2006		\$ 55,335,500.00				
Total:		\$ 286,520,361.90				
Pursuant to T.C.A., Section 9-6-110, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.						
						BCG

AMENDMENT NUMBER 11

**AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN**

THE STATE OF TENNESSEE,

d.b.a. TENNCARE

AND

VOLUNTEER STATE HEALTH PLAN, INC.

CONTRACT NUMBER: FA-02-14632-11

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as follows:

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Amended and Restated Contractor Risk Agreement (CRA) by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Contractor Name, hereinafter referred to as the CONTRACTOR as specified below.

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. Section 1-3 shall be amended by adding the following definitions:

Baseline Assessment Tool (BAT) – Tool provided by the National Committee for Quality Assurance to complete and forward to the approved Health Employer Data and Information Set auditing firm as the initial step in the HEDIS audit.

Clinical Practice Guidelines – Systematically developed tools that help practitioners make decisions about appropriate health care for specific clinical circumstances. Such guidelines are usually evidence-based. See **practice guidelines**.

Community Health Record (CHR)- Person centric data maintained in a data warehouse that is aggregated in the following modules:

- Demographics- Patient and Primary Care Provider
- Allergies
- Immunization records
- Records of medications dispensed
- Visit encounter history (including but not limited to inpatient, outpatient, office visits and emergency room visits)
- Physician orders
- Lab results
- EPSDT status

Consumer Assessment of Health Plans Study (CAHPS) – A set of standardized surveys that measure patient satisfaction with experience of care. CAHPS is sponsored by the Agency for Health Care Quality.

Contributing Data to the Community Health Record – Data provided to the CHR shall include but not be limited to the following:

- Enrollee data maintained by VSHP, Inc.
- TennCare MCC data provided by the TennCare Bureau
- Immunization data provided by the State of Tennessee
- Pharmacy data provided by the TennCare Bureau

Electronic Protected Health Information (EPHI) – A Protected Health Information that is transmitted by or maintained in electronic media (45 C.F.R. Section 160.103).

Health Plan Employer Data and Information Set (HEDIS) – The most widely used set of performance measures used in the managed care industry, designed to allow reliable comparison of the performance of managed health care plans. HEDIS is developed and maintained by the National Committee for Quality Assurance.

National Committee for Quality Assurance (NCQA) – A nonprofit organization committed to assessing, reporting on and improving the quality of care provided by organized delivery systems. Useful information on NCQA may be accessed at the NCQA website: www.ncqa.org

Practice Guidelines – Systematically developed descriptive tools or standardized specifications for care to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances. Practice guidelines are typically developed through a formal process and are based on authoritative sources that include clinical literature and expert consensus. Practice guidelines may also be called **practice parameters, treatment protocols, clinical criteria, or clinical guidelines.**

Privacy Rule - The standards for the Privacy of Individually Identifiable Health Information at 45 C.F.R., Part 160 and Part 164.

Routine Care – Non urgent medical care such as screenings, immunizations, or health assessments.

Security Incident – The attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with the system operations in an information system.

Security Rule – The Security Standards for the Protection of Electronic Health Information at 45 C.F.R., Part 160 and Part 164.

Urgent Care – Any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or
- In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

2. Section 1-3 shall be amended by deleting the definition for "Credentialing Verification Organization".

3. Section 1-3 shall be amended by deleting and replacing the following definitions:

Quality Improvement (QI) – The effort to assess and improve the performance of a program or organization. Quality Improvement includes quality assessment and implementation of corrective actions to address any deficiencies identified.

Services - The benefits described in Section 2-3 of this Agreement.

4. Section 2-1.i and j shall be deleted and replaced so that the amended Sections 2-2.i and j shall read as follows:

- i. The CONTRACTOR shall provide the capability of electronic billing for all of their TennCare plans offered in Tennessee. The CONTRACTOR or any entities acting on behalf of the CONTRACTOR shall not charge providers for filing claims electronically. However, this provision shall not be construed to imply that providers may not be responsible for payment of applicable line fees and/or charges. The CONTRACTOR shall comply at all times with standardized paper billing forms/format as follows:

<u>Claim Type</u>	<u>Claim Form</u>
Professional	CMS 1500
Institutional	UB-92
Pharmacy	NCPDP (Edit Format)
Dental	ADA

The CONTRACTOR shall not revise or modify the standardized form or format itself. Further, the CONTRACTOR agrees to adopt national EMC standards and standardized instructions and definitions that are consistent with industry norms for the forms identified above when developed by TENNCARE in conjunction with appropriate workgroups. This shall include, but not be limited to, federally required safeguard requirements including signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR 455.18 and 455.19 which requires a statement that the provider certifies that s/he is aware that payment is from Federal and State funds and anyone who misrepresents or falsifies essential Medicaid claims information may be prosecuted under Federal and State laws.

As required in Sections 2-4.10, 2-9.7, 2-10.15 and 6 of this Agreement, the CONTRACTOR also agrees to comply with the Health Insurance Portability and Accountability Act (HIPAA). Further, the CONTRACTOR agrees that at such time that TENNCARE in conjunction with appropriate work groups presents recommendations concerning claims billing and processing that are consistent with industry norms, the CONTRACTOR shall comply with said recommendations within one hundred and eighty (180) days from notice by TENNCARE to do so.

The CONTRACTOR agrees to comply with prompt pay claims processing requirements in accordance with TCA 56-32-226.

Failure to comply with the aforementioned claims processing requirements shall result in the CONTRACTOR being required to implement a corrective action plan as described in Section 2-16, and shall result in the application of liquidated damages and/or intermediate sanctions as described in Section 6-8 of this Agreement.

- j. Agree to adhere to the quality standards and HEDIS preventive health standards that are required by TENNCARE. These standards shall be consistent with current NCQA Standards and Guidelines for the Accreditation of MCOs. Further, the CONTRACTOR shall agree to achieve and maintain NCQA Accreditation as described in Section 2-9.6.8 of this Agreement.

5. Section 2-1.o.5 shall be deleted and replaced in its entirety so that the amended Section 2-1.o.5 shall read as follows:

2-1.o. 5. The provider has lost his/her license, failed to report restriction of licensure or loss of privileges or is otherwise not in good standing with the TENNCARE program;

6. Section 2-1.p. shall be deleted in its entirety and the remaining Sections 2-1 shall be renumbered accordingly.

7. Section 2-1 shall be amended by deleting the existing Section 2-1.u in its entirety, adding a new 2-1.t and u. which shall read as follows:

- t. The CONTRACTOR shall complete all necessary requirements to implement changes and process accurately all information necessary to successfully implement the Reform changes in accordance with state or federal law, rule or policy, including but not limited to benefit limits, cost sharing or copays or any other program change for which the MCO provides services. These changes shall be defined by

TENNCARE. The CONTRACTOR agrees to test Reform changes prior to October 1, 2005. TENNCARE shall require the CONTRACTOR to track and report accumulated benefit information effective October 1, 2005; however, limits shall not be imposed on enrollees prior to January 1, 2006 as described in Section 2-3.1 of this Agreement. Failure to successfully test and implement reform changes, as determined by TENNCARE, shall be considered breach of this Agreement and the CONTRACTOR may be subject to termination in accordance with Section 6-2.2 of this Agreement;

u. At such time that TENNCARE develops a provider fee schedule for use by all of the TennCare MCOs, the CONTRACTOR shall agree to implement, within a reasonable timeframe, said fee schedule; and

8. Section 2-3.1 shall be deleted and replaced in its entirety so that the amended Section 2-3.1 shall read as follows:

2-3.1. TennCare Covered Benefits Chart

Effective October 1, 2005, benefits in the TennCare Program as provided by the CONTRACTOR are based on specified eligibility categories.

The CONTRACTOR shall cover, at a minimum, the services and benefits as outlined below.

2-3.1.1 TennCare Benefits, prior to January 1, 2006:

SERVICE	BENEFIT
Inpatient Hospital Services	As medically necessary. Pre-admission approval and concurrent reviews allowed.
Outpatient Hospital Services	As medically necessary.
Physician Inpatient Services	As medically necessary. This shall include acupuncture performed by a Physician or a registered nurse as an anesthetic in connection with a surgical procedure.
Physician Outpatient Services/Community Health Clinic Services/Other Clinic Services	As medically necessary. This shall include acupuncture performed by a Physician or a registered nurse as an anesthetic in connection with a surgical procedure and services provided by a Primary Care Provider with a primary behavioral health diagnosis (ICD-9-CM 290.xx - 319.xx). CONTRACTOR covered services shall also include medical evaluations provided by a neurologist, as approved by the CONTRACTOR, and/or an emergency room provider, that result in a primary behavioral health diagnosis (ICD-9-CM 290.xx - 319.xx).
Lab & X-Ray Services	As medically necessary.
Newborn Services	As medically necessary including circumcisions performed by a physician.
Hospice Care	As medically necessary. Must be provided by an organization certified pursuant to Medicare Hospice requirements. If a Medicaid hospice patient resides in a nursing facility (NF), the CONTRACTOR must pay an amount equal to at least 95 percent of the prevailing NF room and board rate to the hospice provider.
Dental Services	Preventive, diagnostic and treatment services for enrollees under age 21.

	<p>Services for enrollees age 21 or older limited to cases of accidental injury to or neoplasms of the oral cavity, life threatening infections that include, but are not limited to, individuals with severely compromised immune systems, organ donor recipients, or individuals with or scheduled to receive a prosthetic heart valve(s), accidental injury to natural teeth including their replacement (limited to the cost of bridgework or the replacement of teeth injured in an accident unless teeth implants are medically necessary) and the removal of impacted wisdom teeth. (The adult dental "accident" must be caused by some external force, like a car accident, not by some normal act of mastication, or grinding of teeth while sleeping, or any other naturally occurring circumstance and must have occurred during a period of TennCare eligibility and within twelve (12) months from the date service is requested.) Orthodontics limited to individuals under 21 except when an orthodontic treatment plan is approved prior to the enrollee attaining 20 1/2 years of age, and treatment is initiated prior to the recipient attaining 21 years of age, or when orthodontic treatment is the result of facial hemiatrophy or congenital birth defects (if enrollee was covered by TennCare at birth).</p> <p>Effective October 1, 2002, the aforementioned covered dental services shall be provided by the Dental Benefits Manager. The provision of transportation to and from said services as well as the medical and anesthesia services related to the dental service that are not provided by a dentist or in a dentist's office shall remain with the CONTRACTOR.</p> <p>Effective August 1, 2005, unless the CONTRACTOR is otherwise notified by TENNCARE as a result of Waiver and/or Court negotiations, coverage shall be as follows:</p> <p>Medicaid/Standard Eligible, Age 21 and older: Non-covered.</p> <p>Medicaid/Standard Eligible, Under age 21: The CONTRACTOR shall cover Dental preventive, diagnostic and treatment services for enrollees under age 21. Orthodontics limited to individuals under 21 except when an orthodontic treatment plan is approved prior to the enrollee attaining 20 1/2 years of age, and treatment is initiated prior to the recipient attaining 21 years of age.</p> <p>Effective October 1, 2002, the aforementioned covered dental services shall be provided by the Dental Benefits Manager. The provision of transportation to and from said services as well as the medical and anesthesia services related to the dental service that are not provided by a dentist or in a dentist's office shall remain with the CONTRACTOR.</p> <p>(See Section 2-3.a.1, and 2-3.c.3)</p>
<p>Vision Services</p>	<p>Preventive, diagnostic and treatment services (including eyeglasses) for enrollees under age 21. The first pair of cataract glasses or contact lens/lenses following cataract surgery is covered for adults.</p>
<p>Home Health Care</p>	<p>As medically necessary.</p>
<p>Pharmacy Services (obtained directly from an ambulatory retail pharmacy setting, outpatient hospital pharmacy, mail order)</p>	<p>As medically necessary. Non-covered therapeutic classes as described in Section 2-3.13, DESI, LTE, IRS drugs excluded.</p> <p>TENNCARE is responsible for the provision and payment of pharmacy benefits to individuals who are enrolled in the TennCare Program in the category of TennCare Medicaid/Medicare dual eligible. (However, this does</p>

<p>pharmacy or those administered to a long-term care facility resident (nursing facility)</p>	<p>not include pharmaceuticals administered in a doctor's office.)</p> <p>TENNCARE is not responsible for the provision and payment of pharmacy services for TennCare Medicaid/Medicare dual eligibles prior to the date that TENNCARE has notified the CONTRACTOR through the regular electronic eligibility update that these individuals are eligible in the TennCare/Medicare dual eligible category.</p> <p>Effective July 1, 2003, the aforementioned covered pharmacy services shall be provided by the Pharmacy Benefits Manager (PBM) contracted by the TENNCARE Bureau. Pharmacies providing home infusion drugs and biologics <u>only (not including services)</u> shall bill the PBM.</p> <p>Diabetic monitors and supplies as well as injectable drugs obtained directly from a pharmacy provider shall be included in the covered pharmacy services that will be provided by the TennCare Pharmacy Benefit Manager effective July 1, 2003.</p> <p>The CONTRACTOR shall be responsible for reimbursement of injectable drugs obtained in an office/clinic setting in accordance with benefits described herein and to providers providing both home infusion services and the drugs and biologics. Effective July 1, 2005, the CONTRACTOR shall require that all home infusion claims contain NDC coding and unit information to be paid.</p> <p>Effective August 1, 2005, unless the CONTRACTOR is otherwise notified by TENNCARE as a result of Waiver and/or Court negotiations, the Benefit Limits for Pharmacy coverage, as provided by the PBM shall be as follows:</p> <p>Non-Institutionalized Mandatory and Optional (other than Medically Needy) Medicaid Adults and Pregnant Medically Needy Adults: 5 Prescriptions per Month of which only 2 may be Brand name</p> <p>Institutionalized Medicaid Adults: As medically necessary</p> <p>Medically Needy Non-Institutionalized, Non-Pregnant Adults: Non-covered.</p> <p>Standard Eligible, Age 21 and older: Non-covered</p> <p>Medicaid/Standard Eligible, Under age 21: As medically necessary</p>
<p>Durable Medical Equipment</p>	<p>As medically necessary.</p> <p>Specified DME services shall be covered/non-covered in accordance with the TennCare rules and regulations.</p>
<p>Medical Supplies</p>	<p>As medically necessary.</p>
<p>Emergency Ambulance Transportation</p>	<p>As medically necessary.</p>
<p>Non-Emergency Ambulance Transportation</p>	<p>As medically necessary.</p>

<p>Non-Emergency Transportation</p>	<p>As necessary for enrollees lacking accessible transportation for covered services.</p> <p>The travel to access primary care and dental services must meet the requirements of the waiver terms and conditions. The availability of specialty services as related to travel distance should meet the usual and customary standards for the community. However, in the event the MCO is unable to negotiate such an arrangement for an enrollee, transportation must be provided regardless of whether or not the enrollee has access to transportation. If the enrollee is a child, transportation must be provided for the child and an accompanying adult. However, transportation for a child shall not be denied pursuant to any policy which poses a blanket restriction due to enrollees age or lack of parental accompaniment. Any decision to deny transportation of a child due to an enrollee's age or lack of parental accompaniment must be made on a case-by-case basis and must be based on the individual facts surrounding the request. As with any denial, all notices and actions must be in accordance with the appeal process.</p> <p>At such time that TENNCARE carves out the CONTRACTOR's responsibility to provide Dental Services, the provision of transportation to and from said services shall remain with the CONTRACTOR.</p>
<p>Community Health Clinic Services</p>	<p>As medically necessary.</p>
<p>Renal Dialysis Services</p>	<p>As medically necessary.</p>
<p>EPSDT Services for enrollees under age 21 in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.</p>	<p>Screening, interperiodic screening, diagnostic and follow-up treatment services as medically necessary in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989 for enrollees under 21. Except for Dental services, Screens shall be in accordance with the periodicity schedule set forth in the latest "American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care" and all components of the screens must be consistent with the latest "American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care". Dental screens shall be in accordance with the latest periodicity schedule set forth by the American Academy of Pediatric Dentistry and all components of the screens must be consistent with the latest recommendations by the American Academy of Pediatric Dentistry. Tools to be used for screenings shall be consistent with the EPSDT Screening Guidelines as described in Attachment VIII of the Agreement. EPSDT services also include maintenance services which are services which have been determined to be effective in preventing or mitigating the worsening of an individual's conditions or preventing the development of additional health problems.</p>
<p>Rehabilitation Services</p>	<p>As medically necessary when determined cost effective by the MCO.</p> <p>All medically necessary services shall be provided to enrollees under 21 years of age in accordance with EPSDT requirements including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.</p>
<p>Chiropractic Services</p>	<p>When determined cost effective by the MCO.</p>

<p>Private Duty Nursing</p>	<p>As medically necessary and when prescribed by an attending physician for treatment and services rendered by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), who is not an immediate relative.</p> <p>Effective August 1, 2005, Non-Covered for Adults unless the CONTRACTOR is otherwise notified by TENNCARE as a result of Waiver and/or Court negotiations.</p>
<p>Speech Therapy</p>	<p>As medically necessary, by a Licensed Speech Therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic or personality disorder. All medically necessary services shall be provided to enrollees under 21 years of age in accordance with EPSDT requirements including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.</p>
<p>Sitter</p>	<p>As medically necessary, a sitter who is not a relative may be used where an enrollee is confined to a hospital as a bed patient and certification is made by a network physician that R.N. or L.P.N. is needed and neither is available.</p> <p>Effective August 1, 2005, Non-Covered, unless the CONTRACTOR is otherwise notified by TENNCARE as a result of Waiver and/or Court negotiations.</p>
<p>Convalescent Care</p>	<p>Upon receipt of proof that a Covered Person has incurred Medically Necessary expenses related to convalescent care, the Plan shall pay for up to and including the one-hundredth (100th) day of confinement during any calendar year for convalescent facility(ies) room, board and general nursing care, provided: (1) a Physician recommends confinement for convalescence; (2) the enrollee is under the continuous care of a Physician during the entire period of confinement; and (3) the confinement is required for other than custodial care.</p> <p>Effective August 1, 2005, Non-Covered, unless the CONTRACTOR is otherwise notified by TENNCARE as a result of Waiver and/or Court negotiations.</p>
<p>Organ Transplants and Donor Organ Procurement</p>	<p>As medically necessary for a covered organ transplant.</p>
<p>Reconstructive Breast Surgery</p>	<p>In accordance with TCA 56-7-2507, which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy as well as any surgical procedure on the non-diseased breast deemed necessary to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast to establish symmetry with the diseased breast will only be covered if the surgical procedure performed on a non-diseased breast occurs within five (5) years of the date the reconstructive breast surgery was performed on a diseased breast.</p> <p>Note: Applicable CPT procedure codes regarding the revision of undiseased breast following mastopexy or mastectomy for breast cancer, for the purpose of restoring symmetry, shall be the CPT procedures codes in the following range: 19316 – 19396.</p>

2-3.1.2 TennCare Benefits, effective January 1, 2006:

Should TENNCARE eliminate a specified population from eligibility in the TennCare Program, Services/Benefits listed below shall no longer be applicable for said population.

TENNCARE shall provide the CONTRACTOR with a shortlist of services that shall be excluded from benefit limits that are described below.

If at anytime TENNCARE determines that certain benefit limits shall not be imposed or shall be implemented on a different effective date, TENNCARE may notify the CONTRACTOR by written notice. To the extent that there are substantive changes in the benefit design from what is described below, the CONTRACTOR shall have a reasonable time frame to implement said substantive changes.

For purposes of this Section, "Institutionalized Medicaid" shall be defined as individuals who are receiving (as described in TennCare/Medicaid rules and regulations) long term care institutional services in a nursing home, an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or waiver covered services provided through the Home and Community Based Services (HCBS) waiver for these institutional services.

Service	Benefit
<p>Inpatient Hospital Services</p>	<p>Non-Institutionalized Medicaid Eligible, Age 21 and older: Limited to 20 days per calendar year.</p> <p>Institutionalized Medicaid: As medically necessary.</p> <p>Standard Eligible, Age 21 and older: Limited to 5 days per calendar year. NOTE: Age 21 and older: Inpatient rehabilitation hospital facility services may be covered when determined to be a cost-effective alternative by the MCO.</p> <p>Medicaid/Standard Eligible, Under age 21: As medically necessary, rehabilitation hospital facility services are covered under EPSDT.</p> <p>NOTE: All Eligibles: CONTRACTOR may require preadmission approval before hospitalization except for emergencies. CONTRACTOR may conduct concurrent and retrospective review.</p>
<p>Outpatient Hospital Services</p>	<p>Non-Institutionalized Medicaid Eligible, Age 21 and older: Limited to 8 visits per calendar year.</p> <p>Institutionalized Medicaid: As medically necessary.</p> <p>Standard Eligible, Age 21 and older: Limited to 3 visits per calendar year.</p> <p>Medicaid/Standard Eligible, Under age 21: As medically necessary.</p>
<p>Physician Inpatient Services</p>	<p>As medically necessary until applicable Inpatient benefit limits have been exhausted.</p>
<p>Physician Outpatient</p>	<p>Non-Institutionalized Medicaid/Standard Eligible, Age 21 and older: Limited to 12 visits per calendar year.</p>

<p>Services/Community Health Clinic Services/Other Clinic Services</p>	<p>Institutionalized Medicaid: As medically necessary.</p> <p>Medicaid/Standard Eligible, Under age 21: As medically necessary.</p> <p>NOTE: This shall include services provided by a Primary Care Provider with a primary behavioral health diagnosis (ICD-9-CM 290.xx - 319.xx).</p> <p>CONTRACTOR covered services shall also include medical evaluations provided by a neurologist, as approved by the CONTRACTOR, and/or an emergency room provider, that result in a primary behavioral health diagnosis (ICD-9-CM 290.xx - 319.xx).</p>
<p>EPSDT Services for enrollees under age 21 in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.</p>	<p>Medicaid/Standard Eligibles, Age 21 and older: not covered.</p> <p>Medicaid/Standard Eligibles, Under age 21: Covered as medically necessary, except that the screenings do not have to be medically necessary. Children may also receive screenings in-between regular checkups if a parent or caregiver believes there is a problem.</p> <p>Screening, interperiodic screening, diagnostic and follow-up treatment services as medically necessary in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989 for enrollees under 21. Except for Dental services, Screens shall be in accordance with the periodicity schedule set forth in the latest "American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care" and all components of the screens must be consistent with the latest "American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care". Dental screens shall be in accordance with the latest periodicity schedule set forth by the American Academy of Pediatric Dentistry and all components of the screens must be consistent with the latest recommendations by the American Academy of Pediatric Dentistry. Tools to be used for screenings shall be consistent with the EPSDT Screening Guidelines as described in Attachment VIII of the Agreement. EPSDT services also include maintenance services which are services which have been determined to be effective in preventing or mitigating the worsening of an individual's conditions or preventing the development of additional health problems.</p>
<p>Preventive Care Services</p>	<p>As described in Section 2-3. 3.</p>
<p>Lab and X-ray Services</p>	<p>Non-Institutionalized Medicaid/Standard Eligible, Age 21 and older: Limited to 10 visits per calendar year.</p> <p>Institutionalized Medicaid: As medically necessary.</p> <p>Medicaid/Standard Eligible, Under age 21: As medically necessary.</p>
<p>Hospice Care</p>	<p>As medically necessary. Must be provided by a Medicare-certified hospice.</p> <p>If a Medicaid hospice patient resides in a nursing facility (NF), the CONTRACTOR must pay an amount equal to at least 95 percent of the prevailing NF room and board rate to the hospice provider.</p>

<p>Dental Services</p>	<p>Medicaid/Standard Eligible, Age 21 and older: Non-covered.</p> <p>Medicaid/Standard Eligible, Under age 21: The CONTRACTOR shall cover Dental preventive, diagnostic and treatment services for enrollees under age 21. Orthodontics limited to individuals under 21 except when an orthodontic treatment plan is approved prior to the enrollee attaining 20 1/2 years of age, and treatment is initiated prior to the recipient attaining 21 years of age.</p> <p>Effective October 1, 2002, the aforementioned covered dental services shall be provided by the Dental Benefits Manager. The provision of transportation to and from said services as well as the medical and anesthesia services related to the dental service that are not provided by a dentist or in a dentist's office shall remain with the CONTRACTOR.</p> <p>(See Section 2-3.4)</p>
<p>Vision Services</p>	<p>Medicaid/Standard Eligible, Age 21 and older: Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of refractive state), will be covered but shall be subject to the service limitations as described elsewhere in this Agreement. Routine periodic assessment, evaluation, or screening of normal eyes and examinations for the purpose of prescribing fitting or changing eyeglass and/or contact lenses will not be covered.</p> <p>Medicaid/Standard Eligible, Under age 21: Preventive, diagnostic, and treatments services (including eyeglasses), are covered as medically necessary.</p>
<p>Home Health Care</p>	<p>As medically necessary.</p>
<p>Pharmacy Services Note: Pharmacy Benefits delivered by the PBM may have a different effective date regarding benefit limits.</p>	<p>Non-Institutionalized Mandatory and Optional (other than Medically Needy) Medicaid Adults and Pregnant Medically Needy Adults: 5 Prescriptions per Month of which only 2 may be Brand name</p> <p>Institutionalized Medicaid Adults: As medically necessary</p> <p>Medically Needy Non-Institutionalized, Non-Pregnant Adults: Non-covered.</p> <p>Standard Eligible, Age 21 and older: Non-covered</p> <p>Medicaid/Standard Eligible, Under age 21: As medically necessary</p> <p>NOTE: Certain drugs (known as DESI, LTE, or IRS drugs) are excluded from coverage.</p> <p>Limits on Pharmacy benefits as well as the effective dates thereof are subject to change based on Waiver and/or Court negotiations.</p> <p>Effective July 1, 2003, the aforementioned covered pharmacy services shall</p>

	<p>be provided by the Pharmacy Benefits Manager (PBM) contracted by the TENNCARE Bureau. Pharmacies providing home infusion drugs and biologics only (not including services) shall bill the PBM.</p> <p>Diabetic monitors and supplies as well as injectable drugs obtained directly from a pharmacy provider shall be included in the covered pharmacy services that will be provided by the TennCare Pharmacy Benefit Manager effective July 1, 2003.</p> <p>The CONTRACTOR shall be responsible for reimbursement of injectable drugs obtained in an office/clinic setting in accordance with benefits described herein and to providers providing both home infusion services and the drugs and biologics. Effective July 1, 2005, the CONTRACTOR shall require that all home infusion claims contain NDC coding and unit information to be paid.</p> <p>Services reimbursed by the CONTRACTOR shall not be included in the Pharmacy Benefit Limits as described above.</p>
<p>Durable Medical Equipment</p>	<p>As medically necessary.</p> <p>Specified DME services shall be covered/non-covered in accordance with the TennCare rules and regulations.</p>
<p>Medical Supplies</p>	<p>As medically necessary.</p>
<p>Emergency Air And Ground Ambulance Transportation</p>	<p>As medically necessary.</p>
<p>Non-emergency Transportation (including Non-Emergency Ambulance Transportation)</p>	<p>As necessary to get an enrollee to and from covered services, for enrollees not having access to transportation. MCOs may require advance notice of the need in order to timely arrange transportation.</p> <p>The travel to access primary care and dental services must meet the requirements of the waiver terms and conditions. The availability of specialty services as related to travel distance should meet the usual and customary standards for the community. However, in the event the MCO is unable to negotiate such an arrangement for an enrollee, transportation must be provided regardless of whether or not the enrollee has access to transportation. If the enrollee is a child, transportation must be provided for the child and an accompanying adult. However, transportation for a child shall not be denied pursuant to any policy which poses a blanket restriction due to enrollees age or lack of parental accompaniment. Any decision to deny transportation of a child due to an enrollees age or lack of parental accompaniment must be made on a case-by-case basis and must be based on the individual facts surrounding the request. As with any denial, all notices and actions must be in accordance with the appeal process.</p> <p>The CONTRACTOR shall provide transportation to and from Dental Services.</p>
<p>Renal Dialysis Services</p>	<p>As medically necessary.</p>

<p>Private Duty Nursing</p>	<p>Medicaid/Standard eligibles, Age 21 and older: Not covered.</p> <p>Medicaid/Standard eligibles Under age 21: Covered as medically necessary in accordance with EPSDT requirements when prescribed by an attending physician for treatment and services rendered by an R.N. or a L.P.N. who is not an immediate relative.</p>
<p>Speech Therapy</p>	<p>Medicaid/Standard Eligible, Age 21 and older: Covered as medically necessary by a Licensed Speech Therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic or personality disorder.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with EPSDT requirements.</p>
<p>Occupational Therapy</p>	<p>Medicaid/Standard Eligible, Age 21 and older: Covered as medically necessary when provided by a Licensed Occupational Therapist to restore, improve, or stabilize impaired functions.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with EPSDT requirements.</p>
<p>Physical Therapy</p>	<p>Medicaid/Standard Eligible, Age 21 and older: Covered as medically necessary when provided by a Licensed Physical Therapist to restore, improve, or stabilize impaired functions.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with EPSDT requirements.</p>
<p>Organ Transplant And Donor Organ Procurement</p>	<p>Medicaid/Standard Eligible, Age 21 and older: All medically necessary and non-investigational/experimental organ transplants, as covered by Medicare, are covered. These include, but may not be limited to: Bone marrow/Stem cell; Cornea; Heart; Heart/Lung; Kidney; Kidney/Pancreas; Liver; Lung; Pancreas; and Small bowel/Multi-visceral.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with EPSDT requirements. Experimental or investigational transplants are not covered.</p>
<p>Reconstructive Breast Surgery</p>	<p>Covered in accordance with TCA 56-7-2507, which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy, as well as surgical procedures on the non-diseased breast to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast to establish symmetry with the diseased breast will only be covered if the surgical procedure performed on a non-diseased breast occurs within five (5) years of the date the reconstructive breast surgery was performed on a</p>

	diseased breast.
Chiropractic Services	Medicaid/Standard Eligible, Age 21 and older: Not covered. Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with EPSDT requirements.
Sitter	NON COVERED
Convalescent Care	NON COVERED

9. Section 2-3.3 shall be deleted and replaced in its entirety so that the amended Section 2-3.3 shall read as follows:

2-3.3 Preventive Services

The following preventive medical services (identified by applicable CPT procedure codes and ADA procedure codes) shall only be covered in accordance with Section 2-3.1 of this Agreement and subject to any limitations described herein, within the scope of standard medical practice, and shall be exempt from any cost sharing responsibilities as described in Section 2-4.10 of this Agreement. In the event that the CPT codes listed below should be revised, consolidated, separated into individual parts, or replaced in part or in whole by new CPT codes, the services represented by the CPT codes listed below shall remain covered services. It is the responsibility of the CONTRACTOR to assure claims and encounter data reflects current CPT coding. Vision services, hearing services, and laboratory services not specifically listed herein, which are required pursuant to the Medicaid Early Periodic Screening, Diagnosis and Treatment (EPSDT) program for persons eligible for EPSDT under the TennCare Program under age 21, shall be provided in accordance with the latest "American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care" periodicity schedule for such services. Dental services which are required pursuant to the Medicaid Early Periodic Screening, Diagnosis and Treatment (EPSDT) program for persons under age 21, shall be provided in accordance with the latest periodicity schedule set forth by the American Academy of Pediatric Dentistry and all components of the screens must be consistent with the latest recommendations by the American Academy of Pediatric Dentistry. It is the responsibility of the MCO to educate providers as to the importance and necessity of documenting all of the components of the screen, and of using the appropriate codes as directed by TENNCARE to the MCOs. It is also the responsibility of the MCO to communicate this data to TENNCARE as directed.

Preventive Services (excluded from cost sharing)

NEW PATIENT	ESTABLISHED PATIENT
99381 – Initial evaluation < 1 year	99391 – Periodic reevaluation <1 year
99382 – age 1 through 4 years	99392 – age 1 through 4 years
99383 – age 5 through 11 years	99393 – age 5 through 11 years
99384 – age 12 through 17 years	99394 – age 12 through 17 years
99385 – age 18 through 39 years	99395 – age 18 through 39 years
99386 – age 40 through 64 years	99396 – age 40 through 64 years
99387 – age 65 years and over	99397 – age 65 years and over

Counseling and Risk Factor Reduction Intervention (excluded from cost sharing)

INDIVIDUAL	GROUP
99401 – approximately 15 minutes	99411 – approximately 30 minutes
99402 – approximately 30 minutes	99412 – approximately 60 minutes
99403 – approximately 45 minutes	

99404 – approximately 60 minutes	
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Family Planning Services - If not part of a Preventive Services office visit, should be billed using the Counseling and Risk reduction individual codes (99401-99404). Family planning supplies and prescription drugs are also exempt from cost sharing responsibilities.

Prenatal Care (excluded from cost sharing)

59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
59409	Vaginal delivery only (with or without episiotomy and/or forceps);
59410	“ including post partum care
59425	Antepartum care only, 4-6 visits
59426	Antepartum care only, 7 or more visits
59430	Postpartum care only (separate procedure)
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
59515	Cesarean delivery only including postpartum care
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy and/or forceps) and postpartum, after previous cesarean delivery
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery

Other Preventive Services (excluded from cost sharing)

99420	Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal)
90476 – 90749	Immunizations
90465-90474	Immunization administration
99173	Screening test of visual acuity, quantitative, bilateral <21 years of age
92551	Screening test, pure tone, air only (Audiologic function)
92552	Pure tone audiometry (threshold); air only
76090-76092	Mammography Screening
88141-88145, 88147,88148, 88150,88152- 88155, 88164- 88167,88174- 88175	Cervical Cancer Screening

Laboratory: Any laboratory test or procedure listed in the preventive services periodicity schedule when the service CPT code is one of the above preventive medicine codes.

**Preventive Dental Services for Children Under 21 Years of Age
(excluded from cost sharing)**

D1110	Prophylaxis (when billed for children over age 12 and under age 21)
D1120	Prophylaxis
D1203	Topical Application of Fluoride (Prophylaxis not included) - child
D1310	Nutritional Counseling for Control of Dental Disease
D1320	Tobacco Counseling for the Control and Prevention of Oral Disease
D1330	Oral Hygiene Instructions
D1351	Sealant per Tooth

10. Sections 2-3.15 shall be deleted and replaced in its entirety so that the new Section 2-3.15 shall read as follows:

2-3.15. Prenatal Care

The CONTRACTOR shall have policies and procedures to facilitate and take reasonable steps to assist pregnant members in accessing prenatal care. This provision shall apply to enrollees in the plan who become pregnant as well as enrollees who are pregnant on the beginning date of enrollment in the plan. This provision does not intend to require all of the CONTRACTOR's network providers to accept new enrollees. However, the CONTRACTOR shall maintain a provider network consisting of providers who accept new enrollees in accordance with TennCare access standards and shall inform TENNCARE, as required, of network providers who do not accept new enrollees. In the event an enrollee entering the CONTRACTOR's plan is receiving medically necessary prenatal care services the day before enrollment, the CONTRACTOR shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided within or outside the CONTRACTOR's provider network. In the event an enrollee entering the CONTRACTOR's plan is in her second or third trimester of pregnancy and is receiving medically necessary prenatal care services the day before enrollment, the CONTRACTOR shall be responsible for providing continued access to the provider (regardless of network affiliation) through the postpartum period. The CONTRACTOR shall require, as a condition of payment, that the service provider accept the amount paid by the CONTRACTOR or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payor) plus any applicable amount of TennCare cost sharing responsibilities due from the enrollee as payment in full for the service.

MCOs participating in TennCare are required to provide or arrange for the provision of medically necessary medical care to their enrollees beginning on the date of their enrollment in the MCO's plan. This requirement includes not only TennCare enrollees whose eligibility is established through SSI, Medicaid or uninsured/uninsurable applications for TennCare, but also those pregnant women who establish "presumptive eligibility" for TennCare. Effective with the first day of a presumptive eligibility period, the State makes fixed administrative fee payments on behalf of these women to the selected MCO and the MCO is required to provide or arrange for the provision of medical care for their enrollee during this period.

Women who are presumptively eligible are entitled to all TennCare benefits. There shall be a sufficient number of providers in the MCO's network who accept enrollees within each geographical location in which the plan is marketed so that prenatal or other medically necessary medical care is not delayed or denied to these women during their presumptive eligibility period. Additionally, the MCO must make services available out-of-plan, if necessary, to meet the medical needs of a woman enrolled in the MCO's plan as a presumptive eligible.

The CONTRACTOR shall notify all network providers that any unreasonable delay in providing care to a pregnant member seeking prenatal care will be considered a material breach of the network provider's contract with the CONTRACTOR. Delay in care for pregnant enrollees shall mean:

1. Failure of the MCO to respond to an enrollee's request for prenatal care by identifying a maternity care provider to honor a request from an enrollee, including a presumptive eligible enrollee, (or from a primary care provider or patient advocate acting on behalf of an enrollee) for a prenatal care appointment. Accessibility shall be in accordance with the Terms and Conditions for Access to the TennCare Waiver and contained herein as Attachment III unless TENNCARE shall specify more stringent access criteria. Regardless of whether prenatal care is provided by a primary care physician, physician extender or an obstetrician who is not the enrollee's primary care physician, the access standards for primary care physician or extender services shall apply when determining access to prenatal care except for cases of a first prenatal care appointment for women who are past their first trimester of pregnancy on the day they are determined to be eligible. For women who are past their

first trimester of pregnancy on the day they are determined to be eligible, a first prenatal care appointment shall occur within fifteen (15) days of the day they are determined to be eligible; or

2. Failure of a pharmacist within the MCO's provider network to fill a prescription written by a maternity care provider for an enrollee, including an approved presumptive eligible, within the specified time frames for all medically necessary requests as described elsewhere in this Agreement and/or the TennCare rules and regulations. Effective July 1, 2003, pharmacy services, as described in 2-3.1 shall be provided by the Pharmacy Benefits Manager (PBM) contracted by the TENNCARE Bureau.

Failure to provide prenatal care in accordance with the provisions described herein shall result in the CONTRACTOR being required to implement a corrective action plan as described in Section 2-16, and shall result in the application of liquidated damages and/or intermediate sanctions as described in Section 6.8 of this Agreement.

11. The first paragraph of Section 2-3.16 shall be amended by adding a new sentence so that the amended first paragraph shall read as follows:

The CONTRACTOR must have written policies and procedures for an EPSDT program that includes coordinating services with other TennCare providers, providing all medically necessary Title XIX EPSDT services to all eligible individuals under the age of twenty-one (21) regardless of whether the service is included in the Medicaid State Plan, as well as outreach and education. The CONTRACTOR must assure the availability and accessibility of required health care resources and help enrollees and their parents or guardians use these resources effectively. The State EPSDT program shall be referred to as "TENnderCare". The CONTRACTOR shall use "TENnderCare" in describing or naming an EPSDT program or services. This shall include, but not be limited to, all policies, procedures and/or marketing material, regardless of the format or media. No other names or labels shall be utilized. CONTRACTORS may, however, use existing EPSDT materials through December 31, 2004. Any new or reprinted EPSDT materials shall use TENnderCare as of July 1, 2004.

12. Section 2-3.16.1.2.2 through 5 shall be deleted and replaced in their entirety so that the amended Sections 2-3.16.1.2.2 through 5 shall read as follows:

2. a comprehensive unclothed physical exam (the child's growth shall be compared against that considered normal for the child's age and gender);
3. appropriate immunizations schedule according to the most current Advisory Committee on Immunization Practices (ACIP) schedule according to age and health history. The ACIP Recommendations on Immunization Practices are approved by the American Academy of Pediatrics.
4. laboratory tests (including Lead Toxicity Screening appropriate for age and risk factors). All children are considered at risk and must be screened for lead poisoning. All children must receive a screening blood lead test at 12 and 24 months of age. Children between the ages of 36 months and 72 months of age must receive a screening lead blood test if they have not been previously screened for lead poisoning. A blood lead test must be used when screening Medicaid-eligible children. A blood lead test equal to or greater than 10 ug/dl obtained by capillary specimen (finger stick) must be confirmed by using a venous blood sample.
5. health education includes anticipatory guidance based on the findings of the physical and/or dental screening. Health education should include counseling to both parents (guardians) and children to assist in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.

13. Section 2-3.18 shall be amended by adding a new item (e) and renumbering the existing item (e) as (f) so that the amended Section 2-3.18 shall read as follows:

2-3.18 Coordination of MCO and PBM Benefits

In order to assure enrollees assigned to TennCare MCOs continue to receive pharmacy services without interruption during the transition and future coordination of their pharmacy benefits, each MCO shall be required to cooperate in any manner necessary, including but not limited to the following:

- (a) The CONTRACTOR and/or its subcontractor (PBM) shall coordinate and interface with TENNCARE and/or the TennCare contracted PBM in order to exchange data in a media and format acceptable to TENNCARE for the purpose of transitioning necessary information such as authorization requests, refill limits, etc.
- (b) The CONTRACTOR agrees to assure it's providers shall coordinate with the TennCare PBM regarding authorization requests for pharmacy services.
- (c) The CONTRACTOR shall be capable of accepting and maintaining data sent from TENNCARE and/or the TennCare PBM regarding enrollee utilization of pharmacy services. The CONTRACTOR shall utilize pharmacy data for management of enrollee health care.
- (d) The CONTRACTOR shall obtain a report from the pharmacy benefits manager (PBM) when provided by the TennCare PBM, that identifies prescribers who have been listed in the top one-hundred (100) prescribers for three (3) weeks out of a four (4) consecutive week period as having prescribed prescription drugs that are not on the Preferred Drug List (PDL). The CONTRACTOR shall use this report as a basis to contact, by telephone one-hundred percent (100%) of its network prescribers (or a provider practicing with the prescribing physician), who wrote prescriptions within thirty (30) calendar days from the date the report is received, for the purpose of educating the physician about a prescription drug that is on the PDL that the physician may prescribe as an alternative and to encourage the physician to contact the pharmacy and change the prescription accordingly; any prescriber who cannot be identified through a unique DEA number shall be excluded from this requirement.
- (e) CONTRACTOR shall utilize pharmacy lock-in data provided by TENNCARE PBM to identify members for case management services.
- (f) Appeals and member service inquiries related to pharmacy services, provided by the TennCare PBM, shall be the responsibility of TENNCARE and/or the TennCare PBM.

14. Section 2-3.19 shall be deleted and replaced in its entirety so that the amended Section 2-3.19 shall read as follows:

2-3.19 Coordination with the Department of Education

The State has implemented a program to provide federal reimbursement to local education agencies (LEAs) for medical services provided to Medicaid-eligible students in a school setting. These services must be medically necessary and included in the student's Individualized Education Plan (IEP). The purpose of this program is to assist LEAs to provide quality medical services to Medicaid students with special needs. This program does not replace the MCOs obligation to pay for medical services for these enrollees, but allows the school districts the option to receive fee-for-service Medicaid payment directly from TENNCARE where providers are direct employees of the school district or are community providers.

MCOs should continue to reimburse qualified providers for services provided in the school setting, such as services coordinated through Department of Health's Project Teach. MCOs should also continue dialogue with providers and Project Teach Coordinators to establish school-based services for students with special needs.

15. Section 2-4.1.1 shall be deleted and replaced in its entirety so that the amended Section 2-4.1.1 shall read as follows:

2-4.1.1. Availability and Accessibility of Primary Care Services

The CONTRACTOR shall assure that there are primary care providers, willing and able to provide the level of care and range of services necessary to meet the medical needs of the enrollees including those with chronic and acute diseases. There shall be a sufficient number of primary care providers who accept new TennCare enrollees within each geographical location in which the plan is marketed so that each primary care provider has a reasonable caseload not to exceed 2,500 patients for a physician and one-half of this for a physician extender. Primary care providers shall be strategically located so that no enrollee shall be required to travel more than thirty (30) miles or thirty (30) minutes one-way, whichever is less, to a primary care provider in rural area. The PCP time distance requirement for urban areas is twenty (20) miles or thirty (30) minutes one-way. If an enrollee requests assignment to a primary care provider located outside the distance/time requirements and the CONTRACTOR has primary care providers available within the distance/time requirements who accept new enrollees, it shall not be considered a violation of the access requirements for the CONTRACTOR to grant the enrollee's request. However, in such cases the CONTRACTOR shall have no responsibility for providing transportation for the enrollee to access care from this selected provider and the CONTRACTOR shall so notify the enrollee in writing as to whether or not the CONTRACTOR will provide transportation for the enrollee to seek care from the requested provider. In these cases of out-of-area assignment, the CONTRACTOR must allow the enrollee to change assignment to a primary care provider within the distance/time requirements if the enrollee requests such a change.

Appointment and wait times should be in accordance with usual and customary practices. Appointments for routine care should not exceed three weeks from the date of request. Requests for urgent care should not exceed 48 hours. Wait times for scheduled, non-urgent PCP appointments will not exceed forty-five minutes. The CONTRACTOR is required to monitor provider compliance and take corrective action for failure to comply.

16. The Title and the first paragraph of Section 2-4.1.2 shall be deleted and replaced by a new Title and two (2) new paragraphs which shall read as follows:

2-4.1.2. Availability and Accessibility of Specialty Services

The CONTRACTOR shall demonstrate sufficient availability and accessibility to Specialty Services for TennCare enrollees (Specialty Services to include, but not be limited to, Essential Hospital Services, services provided by Centers of Excellence, specialty physician services, hospice care, home health care and rehabilitation services). Sufficient availability and accessibility will be defined as meeting or exceeding the Terms and Conditions of the TennCare waiver as described in Attachment III. Specialty care shall not exceed thirty (30) days for routine care or forty-eight (48) hours for urgent care. Waiting times shall not exceed forty-five (45) minutes. The CONTRACTOR is required to monitor provider compliance and take corrective action for failure to comply.

The CONTRACTOR shall also comply with the standards and measures specified in this section to demonstrate sufficient availability and accessibility of Specialty Services for TennCare enrollees

17. Section 2-4.3 through 2-4.6 shall be deleted and replaced in their entirety and shall read as follows:

2-4.3 Management of Medical Care and Coordination of Care

The CONTRACTOR shall be responsible for the management of medical care and continuity of care for all its TennCare enrollees through the following minimum functions:

- a. Performance of reasonable preventive health case management services, as well as mechanisms to assess the quality and appropriateness of care furnished, appropriate referral and scheduling assistance of enrollees with special health care needs, including those identified through the provision of preventive services;
- b. Documentation of authorized referral services in utilization management system;
- c. Monitoring of enrollees with ongoing medical conditions;

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- d. Identification of enrollees utilizing Emergency Department Services inappropriately to assist in scheduling follow-up care with Primary Care Physician and/or appropriate specialist to improve continuity of care and establish a medical home;
- e. Coordinated hospital and/or institutional discharge planning that includes post-discharge care, as appropriate;
- f. Maintenance of its own internal tracking system which identifies the current preventive services screening status and pending preventive services screening due dates for each enrollee. The Contractor agrees to assist in the development of a tracking system that will identify EPSDT screens, immunizations and lab tests due, dates of service for all EPSDT screens, immunizations and lab tests received, referrals for corrective treatment, whether corrective treatment was provided, and dates of service for corrective treatment and agrees to pilot said system when developed;
- g. Authorization of out-of-plan or out-of-state services which are medically necessary due to an emergency;
- h. Assistance in the coordination of mental health, medical care and other TennCare covered services of enrollees as described in Section 2-3. of this Agreement;
- i. In the event an enrollee entering the MCO's plan is receiving medically necessary TennCare covered services the day before enrollment, the CONTRACTOR shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided within or outside the CONTRACTOR's provider network. The CONTRACTOR must provide continuation of treatment through the lesser of the current period of active treatment, or for up to ninety (90) calendar days for members undergoing active treatment for a chronic or acute medical condition. Continued access to the provider through the postpartum period must be provided for members in their second or third trimester of pregnancy The CONTRACTOR shall assure that the enrollee is held harmless by the provider for the costs of the service or procedure except for applicable TennCare cost sharing amounts. The CONTRACTOR shall require, as a condition of payment, that the service provider accept the amount paid by the CONTRACTOR or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payer) plus any applicable amount of TennCare cost sharing due from the enrollee as payment in full for the service. If the CONTRACTOR's payment to a non-contract provider is less than it would have been for a contract provider and the provider contests the payment amount, the CONTRACTOR shall notify the non-contract provider that the provider may initiate the independent review procedures in accordance with T.C.A. Section 56-32-226 as described in Section 2-18 of this Agreement. If it is medically necessary that care extend beyond thirty (30) days, the CONTRACTOR may require prior authorization for continuation of the services beyond thirty (30) days. Care rendered to a CONTRACTOR's enrollee beyond thirty (30) days that is out-of-plan or out-of-network for which a provider has not sought prior authorization need not be reimbursed;
- j. In the event an enrollee entering the CONTRACTOR's plan is in her second or third trimester of pregnancy and is receiving medically necessary prenatal care services the day before enrollment, the CONTRACTOR shall be responsible for providing continued access to the provider (regardless of network affiliation) through the postpartum period. The CONTRACTOR's plan is receiving medically necessary prenatal care services the day before enrollment, the CONTRACTOR shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided within or outside the CONTRACTOR's provider network until such time as the CONTRACTOR can reasonably transfer the enrollee to a service and/or network provider without impeding service delivery that might be harmful to the enrollee's health. The CONTRACTOR shall require, as a condition of payment, that the service provider accept the amount paid by the CONTRACTOR or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payer) plus any applicable amount of TennCare cost sharing responsibilities due from the enrollee as payment in full for the service;

- k. The CONTRACTOR shall implement mechanisms to assess each TennCare enrollee identified by the State as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals. Enrollees who are dually eligible for TennCare and Medicare are exempt from this requirement. For purposes of Sections 2-4.3(l) and (m), enrollees with special health care needs shall refer to enrollees identified through the Department of Children's Services (DCS), as described in Section 1-3 of this Agreement;
- l. The CONTRACTOR shall implement procedures to share, with other MCOs, BHOs, DBMs and PBMs (as necessary) serving the enrollee, the results of its identification and assessment of any enrollee with special health care needs so that those activities need not be duplicated.

2-4-4. Referrals and Exemptions

The CONTRACTOR shall require enrollees to seek a referral from their PCP or case manager prior to accessing non-emergency specialty services in accordance with, the following provisions:

- a. The CONTRACTOR shall exempt routine dental services for children under age 21 from case manager or PCP referral.
- b. The CONTRACTOR shall implement procedures to share, with other MCOs serving the enrollee, the results of its identification and assessment of any enrollee with special health care needs so that those activities need not be duplicated.
- c. The CONTRACTOR may exempt enrollees from case manager or PCP referral in order to obtain prenatal care from an obstetrician when the enrollee's PCP does not provide prenatal and delivery services. However, if the CONTRACTOR requires a referral in order to obtain prenatal care, the CONTRACTOR shall not require the enrollee to go for an office visit with their PCP in order to obtain the referral.
- d. The CONTRACTOR may exempt routine vision services from case manager or PCP referral.
- e. The CONTRACTOR shall provide all PCPs and Case Managers with a current listing of referral providers. The CONTRACTOR shall supply this listing to all PCPs and Case Managers within thirty (30) days of the effective date of this Agreement. A supplemental listing indicating additions and deletions shall be provided on a quarterly basis thereafter. Quarterly basis for purposes of mailing the supplemental listings shall be based on a calendar year schedule (e.g., Jan. – March, etc.). The electronic, web accessible, version shall be updated at least quarterly so as to accurately reflect current provider availability. A copy of the listing, a data file in a media and format described by TENNCARE and documentation from the MCO's mail room or outside vendor indicating the quantity and date mailed shall be sent to TennCare as proof of compliance by the 30th of the month following each quarter in accordance with the reporting schedules as described in Section 6-8 of this Agreement.
- f. The CONTRACTOR shall support appropriate referral, outreach and scheduling assistance of enrollees needing specialty health care services when requested by providers or as specified in Section 3.
- g. Effective August 13, 2003, the CONTRACTOR must provide for a second opinion from a qualified health care professional within the network, or arrange for the ability of the enrollee to obtain one outside the network, at no cost to the enrollee.
- h. Effective August 13, 2003, the enrollees determined to need a course of treatment or regular care monitoring, the entity must have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs.

2-4.5 Abusive Utilizers of Pharmacy Services

The CONTRACTOR shall send information to TENNCARE and TennCare Program Integrity regarding lock-in candidates. Enrollees who disagree with such restrictions may appeal to TENNCARE such restrictions pursuant to the medically necessary provisions of the TennCare hearing rules. The TENNCARE PBM shall provide a monthly report to the CONTRACTOR listing all members identified for pharmacy lock-in. The CONTRACTOR shall use the report to identify enrollees requiring case management services.

2-4.6 Network Notice Requirements

The CONTRACTOR shall provide notice of changes to its provider network as specified below.

2-4.6.1 Enrollee Notification

- a. Change in PCP. Written notice shall be given immediately to an enrollee by the CONTRACTOR when a change in the enrollee's PCP is made. The notice shall be issued in advance of the PCP change when possible or as soon as the CONTRACTOR becomes aware of the circumstances. The notice content shall be consistent with the notice template provided by TennCare.
- b. PCP Termination. If a PCP ceases participation, the CONTRACTOR shall immediately provide written notice no less than thirty (30) days prior to the effective date of the termination and no more than fifteen (15) days after receipt or issuance of the termination notice, to each enrollee who has chosen the provider as their PCP. Each notice shall include all components identified in the notice template provided by TennCare. The requirement to provide notice thirty (30) days prior to the effective date of termination shall be waived in instances where a provider becomes physically unable to care for members due to illness, a provider dies, the provider fails to provide thirty (30) days advance notice to the CONTRACTOR, the provider moves from the service area and fails to notify the CONTRACTOR or when a provider fails credentialing, and instead shall be made immediately upon the CONTRACTOR becoming aware of the circumstances.
- c. Providers Providing On-going Treatment. If an enrollee is in a prior authorized ongoing course of treatment with any other participating provider who becomes unavailable to continue to provide services to such enrollee and the CONTRACTOR is aware of such ongoing course of treatment, the CONTRACTOR shall immediately provide written notice within fifteen (15) calendar days from the date that the CONTRACTOR becomes aware of such unavailability to such enrollee. Each notice shall include all components identified in the notice template provided by TennCare. The timing requirement for the provision of this notice shall be waived in instances where a provider becomes physically unable to care for members due to illness, a provider dies, the provider moves from the service area and fails to notify the CONTRACTOR or when a provider fails credentialing, and instead shall be made immediately upon the CONTRACTOR becoming aware of the circumstances. The CONTRACTOR must provide continuation of treatment through the lesser of the current period of active treatment, or for up to ninety (90) calendar days for members undergoing active treatment for a chronic or acute medical condition. Continued access to the provider through the postpartum period must be provided for members in their second or third trimester of pregnancy.
- d. Non-PCP Provider Termination. If a non-PCP ceases participation in the MCO, the CONTRACTOR shall immediately provide written notice to enrollees who have been patients of the non-PCP provider. Each notice shall include all components identified in the notice template provided by TennCare. Notice shall be issued no less than thirty (30) days prior to the effective date of the termination of the non-PCP provider termination when possible or immediately upon the CONTRACTOR becoming aware of the circumstances.
- e. Network Deficiency. Upon final notification from TENNCARE of a network deficiency, which shall be based on the requirements of this Agreement and terms and conditions of the waiver (Attachment III), the CONTRACTOR shall immediately provide written notice to enrollees living in the affected area of a provider shortage in the CONTRACTOR's network. The notice content shall be consistent with the notice template provided by TennCare.

2-4.6.2 TennCare Notification

- a. Notice of Subcontractor Termination. When a subcontract that relates to the provision of services to enrollees or claims processing is being terminated between the CONTRACTOR and a subcontractor, the CONTRACTOR shall give at least thirty (30) days prior written notice of the termination to TENNCARE and the TennCare Division, TDCI. Said notices shall include, at a minimum; a CONTRACTOR's intent to change to a new subcontractor for the provision of said services, an effective date for termination and/or change, as well as any other pertinent information that may be needed to access services. In addition to prior written notice, the CONTRACTOR shall also provide TENNCARE with a transition plan, when requested, which shall include, at a minimum, information regarding how prior authorization requests will be handled during and after the transition, how continuity of care will be maintained for the enrollees, etc.
- b. Hospital Termination. Termination of the CONTRACTOR's provider agreement with any hospital, whether or not the termination is initiated by the provider or by the CONTRACTOR, shall be reported by the CONTRACTOR in writing to the Bureau of TennCare no less than thirty (30) calendar days prior to the effective date of the termination.
- c. Other Provider Terminations. The CONTRACTOR shall notify TennCare of any provider termination and submit a template copy of the enrollee notice sent as well as an electronic listing identifying each enrollee to whom a notice was sent as required in Section 2-4.6.1. The CONTRACTOR shall maintain a copy of the actual notice on-site and forward a copy of the notices upon request from TENNCARE. If the termination was initiated by the provider, said notice shall include a copy of the provider's notification to the Contractor.

Furthermore, if termination of the CONTRACTOR's provider agreement with any primary care provider or physician group or clinic, whether or not the termination is initiated by the provider or by the CONTRACTOR, places the CONTRACTOR out of compliance with Section 2-4, such termination shall be reported by the CONTRACTOR in writing to the Bureau of TennCare, in the standard format used to demonstrate compliance with provider network and access requirements, within five (5) working days of the date that the agreement has been terminated.

18. Section 2-4.10.1.13 shall be amended by adding additional text to the existing text so that the amended Section 2-4.10.1.13 shall read as follows:

2.4.10.1.13 The CONTRACTOR shall create and adopt policies and procedures to periodically audit adherence to all HIPAA regulations, and for which CONTRACTOR acknowledges and promises to perform, including but not limited to, the following obligations and actions:

- a. Safeguards. CONTRACTOR agrees to use administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the EPHI CONTRACTOR creates, receives, maintains, or transmits on behalf of TENNCARE.
- b. CONTRACTOR's Agents. CONTRACTOR agrees to ensure that any agent, including a subcontractor, to whom it provides EPHI that was created, received, maintained, or transmitted on behalf of TENNCARE agrees to use reasonable and appropriate safeguards to protect the EPHI.
- c. Notification of Security Incident. CONTRACTOR agrees to report to TENNCARE any use or disclosure of TENNCARE enrollee PHI or of any security incident of which CONTRACTOR becomes aware;

19. The second paragraph of Section 2-4.11 shall be deleted and replaced so that the second paragraph of Section 2-4.11 shall read as follows:

TennCare cost sharing responsibilities shall apply to services other than the preventive services described in Section 2-3. 3 of this Agreement. The current cost share schedule to be used in determining applicable cost sharing responsibilities is included in this Agreement as Attachment XI.

20. The opening paragraph in Section 2-6.2.c.1 shall be amended by adding a new sentence so that the amended opening paragraph shall read as follows:

2-6.2.c.1 Member Handbooks

The CONTRACTOR shall update or develop their member handbook annually unless otherwise specified by TENNCARE. As described by TENNCARE, the annual requirement to update and or develop member handbooks may be delayed or modified as the result of major modifications and/or reform efforts being implemented in the TennCare program. Member handbooks must be approved by TennCare prior to distribution. Member handbooks must be distributed to enrollees within thirty (30) days of receipt of notice of enrollment in the CONTRACTOR's plan. A member handbook must also be distributed to all contracted providers upon initial credentialing and annually thereafter as handbooks are updated. For purposes of providing member handbooks to providers, it shall be acceptable to provide handbooks in electronic format, including but not limited to CD or access via a web link. In situations where there is more than one enrollee in a TennCare case, it shall be acceptable for the CONTRACTOR to mail one (1) member handbook to each address listed for the enrollee's TennCare case number when there is more than one (1) new enrollee assigned to the same case number at the time of enrollment and when subsequent new or updated member handbooks are mailed to enrollees. Should a single individual be enrolled and be added into an existing case, a member handbook new or updated must be mailed to that individual regardless of whether or not a member handbook has been previously mailed to enrollees in the existing case. Upon notice by TENNCARE of material changes, the CONTRACTOR shall make the appropriate revisions to maintain and redistribute the member handbooks immediately. The CONTRACTOR shall as appropriate, maintain and provide two (2) separate versions of the CONTRACTOR's TennCare Member Handbook for the specific population being served for the purpose of describing Medicaid Benefits to the Medicaid population and Standard Benefits to the Standard population. All revisions must be approved by TENNCARE prior to dissemination. Each member handbook shall, at a minimum, be in accordance with the following guidelines:

21. Section 2-6.2.c.1.(j) shall be amended by deleting the reference to "Americans with Disabilities Act of 1975" and replacing it with the reference "Americans with Disabilities Act of 1990".
22. Section 2-6.2.c.1 shall be amended by adding 2 new Sections x and y which shall read as follows:
- x. Shall include right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand; and
 - y. Shall be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
23. Section 2-7.1 shall be deleted in its entirety and replaced by a new Section 2-7.1 which shall read as follows:

2-7.1 Utilization Management

The CONTRACTOR shall develop and maintain a Utilization Management Program Description defining the structures and processes within the CONTRACTOR's utilization management program. The program description shall assign responsibility to appropriate individuals including a designated senior physician. The Utilization Management Program shall be supported by an associated work plan. The program shall be evaluated annually. The Utilization Management Program Description, Annual Evaluation, and Work Plan shall be approved by the appropriate oversight committee within the health plan and be submitted to TENNCARE for approval by April 15th of each year. Analysis of findings and actions taken should be included in the Annual Evaluation.

The CONTRACTOR shall assess provider/office staff satisfaction with the prior authorization (PA) process to identify areas that can be improved. Survey shall be conducted at least annually and report shall be submitted to TennCare by June 15th. The CONTRACTOR shall take strong action to address opportunities for improvement identified from information gathered about satisfaction with the PA process.

The CONTRACTOR shall not place arbitrary maximum limits on the length of stay for enrollees requiring hospitalization and/or surgery. The CONTRACTOR shall not employ, and shall not permit others acting on their behalf to employ utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each TennCare enrollee and his/her medical history. Individual patient characteristics must be considered in the determination of readiness for discharge. This requirement is not intended to limit the ability of the CONTRACTOR to place "tentative" limits on the length of a prior authorization or pre-certification.

- a. Inpatient Care. The Contractor shall provide for methods of assuring the appropriateness of inpatient care. Such methodologies shall be based on individualized determinations of medical necessity and, at a minimum, shall include:
 - i. pre-admission certification upon notification for all non-emergency admissions;
 - ii. a concurrent review program to monitor and review continued inpatient hospitalization (for hospitals that are not reimbursed on a DRG basis), length of stay (for hospitals that are not reimbursed on a DRG basis), outpatient care, or diagnostic ancillary services regarding their appropriateness and medical necessity. In addition, the Contractor shall have a process in place to determine for emergency admissions, based upon medical criteria, if and when a patient can be transferred to a network facility, if presently in a non-network facility. On-site concurrent hospitalization review should occur in 95% of the cases where applicable at the two most frequently utilized hospitals;
 - iii. admission review for urgent and/or emergency admissions, on a retroactive basis when necessary, in order to determine if the admission is medically necessary, and if the requested length of stay for the admission (for hospitals that are not reimbursed on a DRG basis and for outlier DRG cases) is reasonable based upon an individualized determination of medical necessity. Such reviews shall not result in delays in the provision of medically necessary urgent or emergency care;
 - iv. Pre-admission certification should not be employed for admissions for the normal delivery of children;
 - v. Prospective review procedures may also include pre-admission testing criteria and criteria for same day surgery procedures. If inpatient hospital pre-admission certification is utilized authorization or denial must occur within one business day of the request.
- b. Case Management. The Contractor shall maintain a case management program for enrollees. Enrollee participation is voluntary. The CONTRACTOR must document and utilize a systematic approach to identify high risk, unique, chronic, or complex cases that may benefit from intensive medical case management. Enrollees identified through this process must be offered case management/care coordination services. The CONTRACTOR shall develop a process to inform enrollees and providers about the availability of case management programs and to inform the enrollee's PCP when a patient has been assigned to a case management program.

The CONTRACTOR shall utilize pharmacy lock-in data provided by TennCare's PBM to identify members for case management services as appropriate.

- c. Transition of Care. The CONTRACTOR will actively assist members with chronic or acute medical conditions in transitioning to another provider when the current provider has terminated participation with the CONTRACTOR. The CONTRACTOR will allow continuation of treatment through the lesser of the current period of active treatment, or for up to 90 calendar days for members undergoing active treatment

for chronic or acute medical conditions. The CONTRACTOR will allow continued access to the provider through the postpartum period for enrollees in their second or third trimester of pregnancy.

- d. Discharge Planning. The Contractor shall maintain and operate a formalized discharge planning program.
- e. Disease Management. The CONTRACTOR must have in place or develop and implement at least two disease management programs. One shall be a comprehensive diabetes disease management program, the second shall be a maternity management program. The effectiveness of these programs shall be measured using relevant HEDIS indicators and other pertinent outcomes measurements/tools. Disease Management Programs must be consistent with current nationally recognized clinical practice guidelines. The programs shall include a statistically valid methodology designed to measure the impact on health status of participating members. The CONTRACTOR shall provide the State with an analysis of the program's impact as part of the Annual Evaluation of the CONTRACTOR'S Quality Improvement Program. The State reserves the right to review and comment on the programs. In the event the TennCare Bureau contracts with an outside entity for the administration of any Disease Management Program, TENNCARE shall be responsible for the administrative cost of the outside contractual arrangement for the Disease Management Program. However, the CONTRACTOR shall cooperate and participate to the extent practical and feasible with any disease management program as developed and/or described by TENNCARE.
- f. Hospitalizations and Surgeries. The CONTRACTOR must comply with any applicable laws or rules related to length of hospital stay. TENNCARE will closely monitor encounter data related to length of stay and re-admissions to identify potential problems. If indicated, TENNCARE or the EQRO may conduct special studies to assess the appropriateness of hospital discharges.
- g. Prior Authorization
 1. General Rule. If prior authorization of a service is granted by the CONTRACTOR, subcontractor or an agent, payment for the pre-approved service shall not be denied based on the lack of medical necessity, assuming that the enrollee is eligible on the date of service, unless it is determined that the facts at the time of the denial of payment are significantly different than the circumstances which were described at the time that prior authorization was granted. Prior Authorization shall not be required for emergency services. Prior authorization requests shall be reviewed subject to the guidelines described in TennCare Rules 1200-13-13 and 1200-13-14 which include, but are not limited to, provisions regarding decisions, notices, medical contraindication, and the failure of an MCO to act timely upon a request. The CONTRACTOR must use appropriately licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each level of utilization management (UM) decision making. The CONTRACTOR must have written procedures documenting access to Board Certified Consultants to assist in making medical necessity determinations.
 2. At time of Enrollment. In the event an enrollee entering the MCO's plan is receiving medically necessary TennCare covered services the day before enrollment, the CONTRACTOR shall continue to make payment, without any form of prior approval and without regard to whether such services are being provided within or outside the CONTRACTOR's provider network until such time as the CONTRACTOR can reasonably transfer the enrollee to a service and/or network provider without impeding service delivery that might be harmful to the enrollee's health. If it is medically necessary that care extend beyond thirty (30) days, the CONTRACTOR shall require prior authorization for continuation of the services beyond thirty (30) days. Care rendered to an enrollee in the Contractor's plan beyond thirty (30) days that is out-of-plan or out-of-network for which a provider has not sought prior authorization shall not be reimbursed.
 3. Prenatal Care. In the event an enrollee entering the CONTRACTOR's plan is receiving medically necessary prenatal care services the day before enrollment, the CONTRACTOR shall continue to make payment for such medically necessary services, without any form of prior approval and without regard to whether such services are being provided within or outside the CONTRACTOR's provider network until such time as the CONTRACTOR can reasonably

transfer the enrollee to a service and/or network provider without impeding service delivery that might be harmful to the enrollee's health. The CONTRACTOR shall require, as a condition of payment, that the service provider accept the amount paid by the CONTRACTOR or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payor) plus any applicable amount of TennCare cost sharing responsibilities due from the enrollee as payment in full for the service. In the event an enrollee entering the CONTRACTOR's plan is in her second or third trimester of pregnancy and is receiving medically necessary prenatal care services the day before enrollment, the CONTRACTOR shall be responsible for providing continued access to the provider (regardless of network affiliation) through the postpartum period.

4. Notice Requirements. The CONTRACTOR must clearly document and communicate the reasons for each denial in a manner sufficient for the provider and member to understand the denial and decide about appealing the decision. Notice of adverse actions to providers and members regarding prior authorization requests shall be provided within the following guidelines:

(a) Provider Notice. The CONTRACTOR must notify the requesting provider of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider need not be in writing; however, the CONTRACTOR must make a reviewer available to discuss any denial decisions. Information provided to the provider must include how to contact the reviewer.

(b) Enrollee Notice. See notice provisions in TennCare Rule 1200-13-13-.11 and 1200-13-14-.11.

h. Compensation for Utilization Management Activities. CONTRACTOR shall assure, consistent with 42 CFR 438.6(h), and 42 CFR 422.208, that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee, as provided by the Balanced Budget Act of 1997 and the provisions of 42 CFR 438.210(e).

24. The Chart in Section 2-9.1.c regarding Performance Guarantees shall be deleted and replaced in its entirety and shall read as follows:

c. The following performance indicators related to administration and management have been identified for ongoing monitoring. The CONTRACTOR's failure to meet these benchmarks or demonstrate improvement toward benchmark levels of performance shall result in the CONTRACTOR being required to implement a corrective action plan as described in Section 2-16.

Performance Indicator	Data Sources	Metric	Target	Benchmark
Volume of Provider Complaints	Monthly Activity Report	# of provider complaints received relative to number of providers (Complaint is defined as an issue a provider presents to the managed care organization, either in written or oral form, which is subject to resolution by the MCO).	0 percent	MCO specific benchmark. 10% reduction over prior year.

Amendment 11 (cont.)

Performance Indicator	Data Sources	Measure	Target	Benchmark
<p>Claims Payment Accuracy and Timeliness</p>	<p>Claims and Encounter Data</p> <p>Note: Self-reported based on internal audit conducted on statistically valid random sample on a quarterly basis.</p> <p>Audit procedures and sample methodology to be submitted to TDCI for review and approval with first quarter's report.</p>	<p>1. Accuracy: Number of claims processed for payment and paid accurately upon initial submission divided by the total number of claims.</p> <p>2. Timeliness of Clean Claims Processing: Number of clean claims processed within thirty (30) calendar days of receipt divided by the total number of clean claims received (for calculation date of receipt counts as day zero).</p> <p>Timeliness of Clean and Unclean Claims Processing: Number of claims processed and, if appropriate, paid within sixty (60) days of receipt divided by the number of all claims processed (for calculation date of receipt counts as day zero)</p> <p>Processing To be measured and reported monthly</p>	<p>100 percent</p>	<p>Accuracy: 97% of claims are processed or paid accurately upon initial submission</p> <p>Timeliness of Clean Claims Processing: 90% of clean claims are paid within 30 days of receipt of these claims.</p> <p>Timeliness of Clean and Unclean Claims Processing: 99.5% of all claims within sixty (60) days of receipt.</p>

Amendment 11 (cont.)

Performance Indicator	Data Sources	Metric	Target	Benchmark
Call Abandonment rate and call answer timeliness for Utilization Management line.	ACD Line Productivity Reports for calls where the provider/staff called directly into the UM call center or selected a UM call center option and was put in the call queue.	<p>1. Call Abandonment Rate: The number of calls abandoned by the caller or the system before being answered by a live voice divided by the number of calls received by the MCO UM call center (during UM open hours of operation) during the measurement period.</p> <p>2. Call Answer Timeliness: The number of calls answered by a live voice within thirty (30) seconds, divided by the number of calls received by the CONTRACTOR's UM call center(s) (during UM call center open hours of operation) during the measurement period.</p>	Same as Benchmark	<p>Call Abandonment rate: Less than 5% of calls abandoned</p> <p>85% of all Calls answered by a live voice within thirty (30) seconds</p>
Call Abandonment rate and call answer timeliness for Member Services line	<p>ACD Line Productivity Reports for calls where the member called directly into member services or selected a member services option and was put in the call queue.</p> <p>Refer to NCQA HEDIS Technical Specifications for further clarification and changes.</p>	<p>1. Call Abandonment Rate: The number of calls abandoned by the caller or the system before being answered by a live voice. Divided by the number of calls received by the MCO member services call center as (during member services open hours of operation) during the measurement period.</p> <p>2. Call Answer Timeliness: The number of calls answered by a live voice within thirty (30) seconds, divided by the number of calls received by the CONTRACTOR's member services call center(s) (during member services open hours of operation) during the measurement period.</p>	0 percent	<p>Call Abandonment rate: Less than 5% of calls abandoned</p> <p>85% of all Calls answered by a live voice within thirty (30) seconds or the prevailing benchmark established by NCQA</p>

Amendment 11 (cont.)

Performance Indicator	Data Sources	Measure	Target	Benchmark
Specialist Provider Network	CONTRACTOR's credentialing reports	Executed contract is a signed agreement with a provider to participate in the Contractor's network	Same as benchmark	<p>1. <u>Physician Specialists</u>: Executed specialty physician contracts in all areas required by this Agreement for the following nine specialists: cardiology; gastroenterology; neurology; neurosurgery; otolaryngology; ophthalmology; orthopedics; oncology/hematology; and urology.</p> <p>2. <u>Essential Hospital Services</u>: Executed contract with at least one (1) Tertiary Care Center for each essential hospital service</p> <p>3. <u>Center of Excellence for People with AIDs</u>: Executed contract with at least one (1) Center of Excellence for AIDs</p>

Performance Indicator	Data Sources	Metric	Target	Benchmark
Network Adequacy	<p>1. Monthly Provider listings</p> <p>2. Most recent monthly provider listing and random phone surveys conducted by TENNCARE on a quarterly basis</p>	<p>1. Time and travel distance as measured by GeoAccess</p> <p>2. Network validation</p>	Same as Benchmark	<p>1. Provider network includes sufficient numbers and geographical disbursement of providers in order to satisfy the Terms and Conditions for Access of the TennCare Waiver</p> <p>2. At least 90% of records for participating providers on the most recent monthly provider listing can be used to contact the provider and confirm the provider is participating in the MCO's network</p>
Encounter Data Submissions	TennCare Edit Reports	Error Threshold Exceeded	Same as Benchmark	Less than 2% of file contains errors by submission due date
EPSDT Screening and Medical Record Documentation	MCO Encounter Data and Medical Chart Audit	The EPSDT screening ratio, calculated in accordance with specifications for the CMS-416 report, multiplied by the percentage of the required seven (7) screening components that are completed as determined through a statistically valid sample of medical records of the MCO's enrollees	Same as Benchmark	Demonstrated active pursuit and completion of activities designed to increase the CONTRACTOR's EPSDT screening ratio and the percentage of screens that are completed and include all seven (7) required screening components

Amendment 11 (cont.)

Performance Indicator	Data Sources	Measure	Target	Benchmark
CAHPS Survey Report	Annual Member Satisfaction Survey	A set of standardized surveys that measure patient satisfaction with experience of care	Same as Benchmark	Report of annual CAHPS survey results due by June 15 th . Rating of the Healthplan: CONTRACTOR must meet or exceed Medicaid National average as reported in Quality Compass. 2004 rating was 69.9%.
HEDIS Report	Annual HEDIS measurement as required by NCQA	A set of standardized performance measures designed to allow reliable comparison of the performance of managed health care plans	Same as Benchmark	Report of audited HEDIS data due by June 15 th
Provider Satisfaction Survey Report	Annual Provider Satisfaction Survey	Survey of provider satisfaction with Prior Authorization process	Same as Benchmark	Report due by June 15 th
NCQA Accreditation Report	NCQA	Final Accreditation Report in its entirety from NCQA's initial survey and annual revised accreditation status	Same as Benchmark	Accreditation

25. Section 2-9.2.b.2 shall be deleted and replaced in its entirety so that the amended Section 2-9.2.b.2 shall read as follows:
 2. Sufficient full-time clinical and support staff to conduct daily business in an orderly manner, including such functions as administration, accounting and finance, prior authorizations, medical and disease management, marketing, appeal system resolution, and claims processing and reporting, as determined through management and medical reviews;
26. Section 2-9.2.b.6 shall be amended by deleting the reference to "Americans with Disabilities Act of 1975" and replacing it with the reference "Americans with Disabilities Act of 1990".
27. Section 2-9.2.b.9 shall be deleted and replaced in its entirety so that the amended Section 2-9.2.b.9 shall read as follows:
 9. The CONTRACTOR shall identify in writing key contact persons for Contract Administration, Accounting and Finance, Prior Authorizations, Marketing, Claims Processing, Information Systems, Non-discrimination Compliance, Member Services, Provider Services, Appeal System Resolution, Medical Management, Disease Management, HEDIS, CAHPS, NCQA Accreditation and EPSDT within thirty (30) days of Agreement execution. Any changes in staff persons during the term of this Agreement must be made in writing within ten (10) business days.

28. Section 2-9.2.b. shall be amended by adding a new Section 2-9.2.b.14 which shall read as follows:

2-9.2.b.14. The CONTRACTOR shall appoint specific staff to an internal audit department which shall report directly to the board of directors or other such appropriate level of management. The CONTRACTOR shall submit an annual Audit Plan to TENNCARE. The importance of an internal audit function is to provide an independent review and evaluation of the accuracy of financial recordkeeping, the reliability and integrity of information, the adequacy of internal controls, and compliance with applicable laws, policies, procedures, and regulations. The internal audit function shall be responsible for performing audits to ensure the economical and efficient use of resources by all departments to accomplish the objectives and goals for the operations of the department. Further, the internal audit department(s) shall be responsible for performance of the claims payment accuracy tests as described in Section 2-9 and 2-9.7.1 of this Agreement.

29. Section 2-9.6 shall be deleted and replaced in its entirety so that the amended Sections 2-9.6 shall read as follows:

2-9.6 Quality Monitoring/Quality Improvement (QM/QI) Program

The CONTRACTOR shall have a written Quality Improvement (QI) Program which clearly defines its quality improvement structures and processes and assigns responsibility to appropriate individuals. This Program shall use as a guideline the current NCQA Standards and Guidelines for the Accreditation of MCOs and shall include the MCO's plan for improving patient safety. The CONTRACTOR shall agree to achieve and maintain NCQA Accreditation. NCQA Accreditation must be achieved by December 31, 2006 and maintained thereafter. Additionally, for new MCOs contracting with TENNCARE, the Program shall be approved by TENNCARE prior to the enrollment of any TennCare enrollees. Any changes to the QI program structure shall require prior written approval from TENNCARE. The QI Program Description and associated work plan shall be submitted to TENNCARE annually for approval along with the Annual Evaluation of QI Program. The QI evaluation of the QI Program for the prior year; the revised QI Program Description and associated Work Plan shall be submitted to TENNCARE following approval by the CONTRACTOR's Quality Improvement Committee, no later than April 15th each year.

2-9.6.1 QM/QI Meeting Requirements

The CONTRACTOR shall provide the Chief Medical Officer of TENNCARE with ten (10) days advance notice of all regularly scheduled meetings of the Quality Improvement Committee and Peer Review Committee. The Chief Medical Officer of TENNCARE, or his/her designee, may attend the Quality Improvement Committee and/or Peer Review Committee meetings at his/her option. In addition, written minutes shall be kept of all meetings of the Quality Improvement Committee and Peer Review Committees. A copy of the signed and dated written minutes for each meeting shall be available on-file after the completion of the following committee meeting in which the minutes are approved and shall be available for review upon request and during the annual on-site EQRO review and/or NCQA Accreditation review.

2-9.6.2. Clinical and Service Quality Improvement Activities

The CONTRACTOR shall select three (3) clinical and two (2) service quality improvement activities relevant to the enrollee population or as required to obtain NCQA Accreditation. The following must be documented for each activity:

- Rationale for selection as a quality improvement activity
- Specific population targeted, include sampling methodology if relevant
- Metrics to determine meaningful improvement and baseline measurement
- Specific interventions (enrollee and provider)
- Relevant clinical practice guidelines
- Date of re-measurement

The CONTRACTOR shall electronically submit Quality Improvement Activity Forms as required by NCQA. These forms are available at www.NCQA.org.

Further, the CONTRACTOR shall update and submit quarterly the Quality Improvement Activities Update Grid along with a brief narrative and barrier analysis explaining any delays encountered for any of the planned activities and the plan for completing any delayed scheduled activities.

2-9.6.3. Clinical Practice Guidelines

The CONTRACTOR shall select at least four (4) evidence-based clinical practice guidelines from recognized sources that are relevant to the enrollee population. Guidelines must be distributed to all appropriate providers. The MCO shall measure performance against at least two (2) important aspects of each of the four (4) clinical practice guidelines annually. The guidelines must be reviewed and any revisions distributed to appropriate providers at least every two (2) years or whenever national guidelines change.

2-9.6.4 Performance Indicators

Performance indicator results shall be reported to TENNCARE within the Annual Evaluation of the Quality Improvement Program. Audited HEDIS and CAHPS results, including audit findings, shall be reported to TENNCARE by June 15th of each calendar year.

The CONTRACTOR's QI Work Plan shall identify benchmarks and set achievable performance goals for each selected quality measure. The source of the benchmark should be identified, i.e., Quality Compass. To be considered meaningful, the CONTRACTOR must demonstrate improvement against the baseline measure as indicated:

Baseline Rate	Minimum Effect Size
0-59	At least a 6 percentage point increase
60-74	At least a 5 percentage point increase
75-84	At least a 4 percentage point increase
85-92	At least a 3 percentage point increase
93-96	At least a 2 percentage point increase
97-100	At least a 1 percentage point increase

The CONTRACTOR's failure to demonstrate meaningful improvement toward benchmark levels of performance shall result in the CONTRACTOR being required to implement a corrective action plan as described in Section 2-16.

2-9.6.5 EPSDT

The CONTRACTOR shall demonstrate at least a 10 percentage-point improvement over the average MCO fiscal year 2000 EPSDT adjusted periodic screening percentage (APSP) for SSI children and at least a 10 percentage-point improvement over the average fiscal year 2000 APSP EPSDT screening rate for all other children enrolled in TennCare Select.

To encourage significant improvement in EPSDT screening rates, the CONTRACTOR may recommend a program designed to increase screening rates through the use of financial incentives. TennCare must approve the program design and amount of any payments prior to distribution.

As specified at 2-4.9, the CONTRACTOR shall contract with each Department of Health for the provision of EPSDT services in the community service area(s) in which it is authorized to serve until such time as it obtains an APSP of eighty percent (80%).

2-9.6.6 Medical Records Requirements

The CONTRACTOR shall maintain, when appropriate, and shall require contracted providers to maintain medical records in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review. Medical records are to be maintained at the site where medical services are provided for each member enrolled under this Agreement. The CONTRACTOR shall have policies and distribute policies to practice sites that address:

1. Confidentiality of medical records
2. Medical record documentation standards
3. An organized medical record keeping system and standards for the availability of medical records
4. Performance goals to assess the quality of medical record keeping
5. CONTRACTOR medical record keeping policies and practices must be consistent with current NCQA Standards for medical record documentation.

2-9.6.7. Credentialing and Recredentialing

The CONTRACTOR utilizes current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent practitioners with whom it contracts or employs and who fall within its scope of authority and action.

2-9.6.8 NCQA Accreditation

NCQA Accreditation must be achieved by December 31, 2006 and maintained thereafter. In order to assure that the CONTRACTOR is making forward progress, TENNCARE shall require the following information and/or benchmarks be met:

EVENT	REQUIRED DEADLINE
CALENDAR YEAR 2005	
Submit preliminary HEDIS data to EQRO as required by the CRA	July 1, 2005
Submit locked DST to NCQA	July 15, 2005
Purchase NCQA ISS Tool for 2006 MCO Accreditation Survey	August 1, 2005
Utilize the NCQA approved Quality Improvement Activity Form to submit baseline data, barrier analysis, and planned interventions for three (3) Clinical and two (2) Service Improvement Studies selected by MCO.	September 15, 2005
NCQA Accreditation Survey Application Submitted and Pre Survey Fee paid	November 15, 2005
Copy of signed contract with NCQA approved vendor to perform 2006 CAHPS Survey to TENNCARE	November 15, 2005
Copy of signed contract with NCQA approved vendor to perform 2006 HEDIS Audit to TENNCARE	November 15, 2005
Submit copy of signed NCQA Survey Contract to TENNCARE	December 15, 2005
Notify TennCare of date for ISS Submission and NCQA Onsite review	December 31, 2005
CALENDAR YEAR 2006	
HEDIS Baseline Assessment Tool completed and submitted to Contracted HEDIS Auditor and TennCare	February 15, 2006
Audited Medicaid HEDIS and CAHPS results submitted to NCQA and TennCare	June 15, 2006
Finalize preparations for NCQA Survey (final payment must be submitted to NCQA 60 days prior to submission of ISS.	July 1 – September 15, 2006
Submit ISS to NCQA	No later than September 18, 2006
NCQA Survey Completed and copy of NCQA Final Report to TennCare:	December 31, 2006

<ul style="list-style-type: none"> • Excellent, Commendable, or Accredited • Provisional – Corrective Action required to achieve status of Excellent, Commendable, or Accredited; resurvey within 12 months. Plan of Corrective Action addressing deficiencies noted by NCQA to TennCare within thirty (30) days of receipt of Final Report from NCQA. Provisional status may result in the assessment of liquidated damages or termination of this Agreement. • Accreditation Denied – Results in termination of this Agreement 	
CALENDAR YEAR 2007	
Complete NCQA Reconsideration Process (if necessary)	January 1, 2007- March 30, 2007
Complete Provisional NCQA Accreditation Resurvey NOTE: Provisional NCQA Accreditation may result in the assessment of liquidated damages or termination of this Agreement	December 31, 2007
Maintain NCQA Accreditation	On-going
Audited Medicaid HEDIS and CAHPS results submitted to NCQA and TennCare	June 15, 2007
Notify TENNCARE of any revision to accreditation status based HEDIS score	Annually immediately upon notification by NCQA
CALENDAR YEAR 2008	
Maintain NCQA Accreditation	On-going
Audited Medicaid HEDIS and CAHPS results submitted to NCQA and TennCare	June 15, 2008
Notify TENNCARE of any revision to accreditation status based HEDIS score	Annually immediately upon notification by NCQA

The CONTRACTOR may obtain additional payments for the successful achievement of NCQA Accreditation as described in Section 5-1.h of this Agreement.

If the CONTRACTOR consistently fails to meet the timelines as described above, the CONTRACTOR shall be considered to be in breach of the terms of this Agreement and may be subject to termination in accordance with Section 6-2.2 of this Agreement. Further, failure to achieve specified benchmarks or reporting requirements, as described in Section 6-8.2.2 shall result in damages as described therein.

Failure to obtain NCQA Accreditation by December 31, 2006 and maintain Accreditation thereafter, shall be considered a breach of this Agreement and shall result in termination of this Agreement in accordance with the terms set forth in Section 6-2.2 of this Agreement. Achievement of Provisional accreditation status shall require a corrective action plan and may result in termination of this Agreement.

30. Section 2-9.7 shall be amended by deleting and replacing 2-9.7.b and d, and adding a new Section 2-9.7.l and renumbering the existing 2-9.7.l as 2-9.7.m so that the new Section 2-9.7.b, d and 2-9.7.l shall read as follows:

- b. Timeliness of Payment. The CONTRACTOR shall have in place, an automated claims processing system capable of accepting and processing claims submitted electronically with the exception of claims that require written documentation to justify payment (e.g., hysterectomy/sterilization consent forms, Certification for Medical Necessity for Abortion, necessary operative reports, etc.). To the extent that the

CONTRACTOR compensates providers on a fee for service or other basis requiring the submission of claims as a condition to payment, the CONTRACTOR shall process, as described herein, the provider's claims for covered benefits provided to enrollees consistent with applicable CONTRACTOR policies and procedures and the terms of this Agreement. The CONTRACTOR shall ensure that ninety percent (90%) of claims for payment for services delivered to a TennCare enrollee (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) days of the receipt of such claims. The CONTRACTOR shall process, and if appropriate pay, within sixty (60) days ninety-nine point five percent (99.5%) of all provider claims for services delivered to an enrollee in the TennCare program. The terms "processed and paid" are synonymous with terms 'process and pay' of Tennessee Code Annotated § 56-32-226(b)(1)(A) and (B). If a claim is partially or totally denied on the basis the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written notice must specifically identify all such information and documentation. Resubmission of a claim with further information and/or documentation shall constitute a new claim for purposes of establishing the time frame for claims processing. If requested by the provider, the CONTRACTOR shall provide an electronic status report indicating the disposition for every adjudicated claim for each claim type submitted by providers seeking payment as well as payments generated and paid by the MCO. The status report shall contain appropriate explanatory remarks related to payment or denial of the claim.

To the extent that the provider agreement requires compensation of a provider on a monthly fixed fee basis or on any other basis that does not require the submission of a claim as a condition to payment, such payment shall be made to the provider by no later than (i) the time period specified in the contract between the provider and the CONTRACTOR or subcontractor, or if a time period is not specified in the contract (ii) the tenth (10th) day of the calendar month if the payment is to be made by a subcontractor, or (iii) if the CONTRACTOR is required to compensate the provider directly, within five (5) calendar days after receipt of the payment and supporting Remittance Advice information from TENNCARE.

The CONTRACTOR shall contract with independent reviewers for the purposes of said reviewers to review disputed claims as provided by T.C.A., Section 56-32-226.

- d. Standard Forms and Billing Instructions. The CONTRACTOR shall not revise or modify the standardized forms or format itself specified in item b. above. Further, the CONTRACTOR agrees to adopt national EMC standards and standardized instructions and definitions that are consistent with industry norms for the forms identified above when developed by TENNCARE in conjunction with appropriate workgroups. This shall include, but not be limited to, federally required safeguard requirements including signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR 455.18 and 455.19 which requires a statement that the provider certifies that s/he is aware that payment is from Federal and State funds and anyone who misrepresents or falsifies essential Medicaid claims information may be prosecuted under Federal and State laws.
1. Claims Payment Accuracy – Minimum Audit Procedures. The quarterly claims payment accuracy percentage is self-reported and is based on an audit conducted by the internal audit staff. The audit will utilize a random sample of all "processed or paid" claims upon initial submission in each quarter (the terms "processed and paid" are synonymous with terms 'process and pay' of Tennessee Code Annotated § 56-32-226(b)(1)(A) and (B)).

A minimum sample of size of 300 claims randomly selected from the entire population of electronic and paper claims processed or paid upon initial submission for the quarter tested is required. Combining the results of minimum sub-samples of 100 randomly selected from the entire population of claim processed and paid upon initial submission for each month in the quarter is acceptable. The minimum attributes to be tested for each claim selected must include:

- Claim data correctly entered into the claims processing system
- Claim is associated to the correct provider
- Service obtained the proper authorization
- Member eligibility at processing date correctly applied

Amendment 11 (cont.)

- Allowed payment amount agrees with contracted rate
- Duplicate payment of the same claim has not occurred
- Denial reason applied appropriate
- Copayment application considered and applied
- Effect of modifier codes correctly applied
- Processing considered if service subject to benefit limits considered and applied
- Other insurance properly considered and applied

For audit and verification purposes, the population of claims should be maintained. Additionally, the results of testing at a minimum should be documented to include:

- Results for each attribute tested for each claim selected
- Amount of overpayment or underpayment for claims processed or paid in error
- Explanation of the erroneous processing for each claim processed or paid in error
- Determination if the error is the result of keying errors or the result of errors in the configuration or table maintenance of the claims processing system
- Claims processed or paid in error have been corrected

31. Section 2-9.h.6.c shall be deleted and replaced in its entirety and shall read as follows:

c. Provider Profiling. The CONTRACTOR shall profile TennCare Select providers and Best Practice Network Primary Care Providers. A summary of Provider profiling activities will be provided to the TennCare Chief Medical Officer quarterly. The summary will include a listing of providers whose profiling revealed practice patterns greater than or equal to two standard deviations from the norm within the CONTRACTOR's network. The summary should include specific actions taken for identified outliers. Provider profiling will include, but not be limited to, the following:

1. Out-of-Network Utilization. The CONTRACTOR shall maintain a procedure to identify and evaluate enrollee out-of-network utilization by PCP panel (including BPN-PCPs),
2. Specialist Referrals. The CONTRACTOR shall maintain a procedure to identify and evaluate enrollee Specialty provider utilization by PCP panel (including BPN-PCPs)
3. Emergency Room Utilization. The CONTRACTOR shall maintain a procedure to identify and evaluate enrollee emergency room utilization by PCP panel. Individual enrollees who establish a pattern of accessing emergency room services should be referred to case management for follow-up.
4. Inpatient Admissions. The CONTRACTOR shall maintain a procedure to identify and evaluate enrollee utilization of inpatient services by PCP panel.
5. Pharmacy Utilization (Generic versus Brand Name). The CONTRACTOR shall maintain a procedure to incorporate pharmacy utilization (generics versus brand names) into the PCP profile.
6. Advanced Imaging Procedures. The CONTRACTOR shall maintain a procedure to identify and evaluate utilization of advanced imaging procedures by PCP panel. Advanced Imaging Procedures include: PET Scans; CAT Scans and MRIs.

32. Section 2-10.6 shall be deleted in its entirety and replaced by new Sections 2-10.6 which shall read as follows:

2-10.6. Monthly Activity Reporting

The CONTRACTOR shall provide electronic monthly activity reports to TENNCARE that include the following:

1. MEMBER SERVICES CALL REPORTING:

- a. Call Answer Timeliness Rate: The number of calls answered by a live voice within thirty (30) seconds, divided by the number of calls received by the CONTRACTOR's member services call center(s) (during member services open hours of operation) during the month/quarter. Calls where the member called directly into member services or selected a member services option and was put in the call queue. Please include detailed rate calculation.
- b. The average wait time spent in queue for members calling the member services call center(s)
- c. Call Abandonment Rate: The number of calls abandoned by the caller or the system before being answered by a live voice divided by the number of calls received by the CONTRACTOR's member services call center as (during member services open hours of operation) during the month/quarter. Calls where the member called directly into member services or selected a member services option and was put in the call queue.

2. UTILIZATION MANAGEMENT CALL REPORTING:

- a. Provider Call Answer Timeliness: The number of calls answered by a live voice within thirty (30) seconds, divided by the number of calls received by the CONTRACTOR's utilization management call center(s) (during hours of operation) during the month/quarter. Calls where the provider called directly into utilization management or selected a utilization management option and was put in the call queue. Please include detailed rate calculation.
- b. The average wait time spent in queue for providers requesting prior authorization.
- c. Provider Call Abandonment Rate: The number of calls abandoned by the caller or the system before being answered by a live voice divided by the number of calls received by the CONTRACTOR's utilization management call center as (during open hours of operation) during the month/quarter. Calls where the provider called directly into utilization management or selected a utilization management option and was put in the call queue.
- d. Number of provider complaints received, either in writing or by phone during the month/quarter.

The minimum data elements and required format for the monthly reports can be found in Attachment XII, Exhibit I of this Agreement.

33. Section 2-10.7. shall be amended by adding a new 3 so that the new 2-10.7.3 shall read as follows:

2-10.7.3 Community Health Record for TennCare Enrollees (Electronic Medical Record)

The CONTRACTOR shall provide agreed upon services, as described in Section 2-28 of this Contract, to implement a Community Health Record for TennCare enrollees. The electronic health record format and design will comply with HIPAA regulations. Access to information will vary based on the specific user.

34. Sections 2-10.13, shall be deleted and replaced in their entirety so that the amended Sections 2-10.13 shall read as follows:

2-10.13. Quality Improvement Reports

2-10.13.1. Annual Review and Approval of the Quality Improvement Program

The CONTRACTOR must submit to TENNCARE an approved (by the CONTRACTOR's QI Committee) copy of the Annual Evaluation of the QI Program, a revised Quality Improvement Program Description and companion Work Plan, annually by April 15th. This report shall be submitted electronically.

2-10.13.2. Quarterly Quality Improvement Activities Update

The CONTRACTOR shall update and submit quarterly the Quality Improvement Activities Update Grid along with a brief narrative and barrier analysis explaining any delays encountered for any of the planned activities and the plan for completing any delayed scheduled activities. This report shall be submitted electronically.

2-10.13.3. PCP Assignment

The CONTRACTOR shall submit a report to TENNCARE including the total number of enrollees and percentage of total enrollees in each Grand Region that have not been assigned to a primary care provider (PCP) within thirty (30) days of enrollment, on a quarterly basis. This report shall be submitted electronically.

2-10.13.4. Quality Improvement Reporting

Results for quality indicators, including audited CAHPS and HEDIS results are to be submitted to TENNCARE by June 15th annually.

Updates for Disease Management Programs, the three (3) clinical and two (2) service quality improvement activities shall be submitted to the State as part of the quarterly quality update. A brief narrative for each of these activities, delineating specific activities which occurred during the reporting period, should be included. This report shall be submitted electronically.

2-10.13.5. EPSDT Reporting

The CONTRACTOR shall submit a completed quarterly EPSDT Report utilizing the form provided within ATTACHMENT II, Exhibit H.3. This report shall be submitted electronically.

2-10.13.6. NCQA Accreditation Status Update

The CONTRACTOR shall submit its NCQA Accreditation Report immediately upon receipt, not to exceed ten (10) calendar days from notification by NCQA.

35. Section 2-10 shall be amended by adding a new Section 2-10.17 which shall read as follows:

2-10.17 Subcontracted Claims Processing Report

Where the CONTRACTOR has subcontracted claims processing for TennCare claims, the CONTRACTOR shall provide to the TennCare Bureau a Type II examination based on the Statement on Auditing Standards (SAS) No. 70, Service Organizations for each non-affiliated organization processing claims that represent

more than 20% of TennCare medical expenses of the CONTRACTOR. This report shall be performed by an independent auditor ("service auditor") and shall be due annually as a Contract Deliverable on May 1 for the preceding year operations or portion thereof. In a Type II report, the service auditor will express an opinion on (1) whether the service organization's description of its controls presents fairly, in all material respects, the relevant aspects of the service organization's controls that had been placed in operation as of a specific date, and (2) whether the controls were suitably designed to achieve specified control objectives, and (3) whether the controls that were tested were operating with sufficient effectiveness to provide reasonable, but not absolute, assurance that the control objectives were achieved during the period specified. The audit of control activities over information and technology related processes related to TennCare claims processing by the subcontractor should include the following:

1. General Controls

- Personnel Policies
- Segregation of Duties
- Physical Access Controls
- Hardware and System Software
- Applications System Development and Modifications
- Computer Operations
- Data Access Controls
- Contingency and Business Recovery Planning

2. Application Controls

- Input
- Processing
- Output
- Documentation Controls

36. Section 2-17.a.3 shall be amended by deleting the word "industry" and replacing it with the word "NCQA" so that the amended Section 2-17.a.3 shall read as follows:

3. The CONTRACTOR shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review, on at least an annual basis, consistent with NCQA standards or State MCO laws and regulations.

37. Section 2-17.d shall be deleted and replaced in its entirety so that the amended Section 2-17.d shall read as follows:

- d. Quality of Care. If the subcontract is for the purpose of securing the provision of enrollee benefits, the subcontract must specify that the subcontractor adhere to the Quality requirements the CONTRACTOR is held to.

38. Section 2-17.h shall be amended by adding additional text to the end of the existing text so that the amended Section 2-17.h shall read as follows:

- h. Claims Processing. All claims for services furnished to a TennCare enrollee filed with a CONTRACTOR must be processed by either the CONTRACTOR or by one (1) subcontractor retained by the organization for the purpose of processing claims. However, another entity can process claims related to pharmacy (effective July 1, 2003 TENNCARE shall contract directly with a PBM for the provision of pharmacy services as described in Section 2-3.1, vision, lab or transportation if that entity has been retained by the CONTRACTOR to arrange and provide for the delivery of said services.

Where the CONTRACTOR has subcontracted claims processing for TennCare claims, the CONTRACTOR shall provide to the TennCare Bureau a Type II examination based on the Statement on Auditing Standards (SAS) No. 70, Service Organizations for each non-affiliated organization processing claims that represent more than 20% of TennCare medical expenses of the CONTRACTOR. This report shall be provided in accordance with Section 2-10.s of this Agreement.

Amendment 11 (cont.)

39. Section 2-18.f. shall be deleted in its entirety and replaced by a new Section 2-18.f which shall read as follows:
- 2-18. f. Specify that the provider may not refuse to provide covered medically necessary or covered preventive services to a child under the age of twenty-one (21) or a TennCare Medicaid patient under this Agreement for non-medical reasons. The CONTRACTOR may require that a TennCare Standard adult pay applicable TennCare cost share responsibilities prior to receiving non-emergency services. However, the provider shall not be required to accept or continue treatment of a patient with whom the provider feels he/she cannot establish and/or maintain a professional relationship;
40. Section 2-18.1 shall be amended by adding references to HEDIS, NCQA, EQRO, and EPSDT so that the amended Section 2-18.1 shall read as follows:
- 2-18. 1. Require that any and all records be maintained for a period not less than five (5) years from the close of the agreement and retained further if the records are under review or audit until the review or audit is complete. Said records shall be made available and furnished immediately upon request for fiscal audit, medical audit, medical review, utilization review, HEDIS, NCQA, EQRO, EPSDT, and other periodic monitoring upon request of authorized representative of the CONTRACTOR or TENNCARE and authorized federal, state and Comptroller personnel;
41. Section 2-18.ii shall be deleted and replaced in its entirety so that the amended Section 2-18.ii shall read as follows:
- 2-18. ii. Specify provider actions to improve patient safety and quality;
42. Section 2-24 shall be amended by deleting the reference to "Americans with Disabilities Act of 1975" and replacing it with the reference "Americans with Disabilities Act of 1990".
43. Section 2-24.a. shall be amended by deleting and replacing the words "Title VI" with the words "non-discrimination".
44. Section 2-25 shall be deleted and replaced in its entirety so that the amended Section 2-25 shall read as follows:
- 2-25 *Processing and Payment of Supplemental Payments***

Subject to the availability of State and Federal funding, the CONTRACTOR agrees to make supplemental pool payments to Meharry Medical Services Foundation or Meharry Dental Clinic. These payments represent unreimbursed TennCare costs of the Meharry Medical College clinics as determined by a review of an independent CPA and in accordance with the methodology approved by the Centers for Medicare and Medicaid Services. Clinical services are performed by Meharry Medical College faculty physicians through the Meharry Dental Clinic and the Meharry Medical Services Foundation. The payment by the CONTRACTOR to the clinic(s) will be made within 10 calendar days of the receipt of such payment by the CONTRACTOR from TENNCARE. The CONTRACTOR may deposit these funds in the account of its choice and may retain all interest earned as compensation for providing this service. The CONTRACTOR agrees to include any correspondence requested by TENNCARE to be included with the payment and provide a written confirmation of any disbursements including the date the check was mailed and the date redeemed.

- a. Payments to the Meharry Medical Services Foundation and/or the Meharry Dental Clinic under this amendment shall not exceed \$5,391,252.00 for State fiscal year 2003. In addition to any interest earned, TENNCARE agrees to pay the CONTRACTOR a sum sufficient to administer this amendment in accordance with state law. The total obligation to the CONTRACTOR under this amendment including the supplemental payment to Meharry Medical Services Foundation and/or the Meharry Dental Clinic shall not exceed \$5,501,276.28 for State fiscal year 2003.
- b. Payments to the Meharry Medical Services Foundation and/or the Meharry Dental Clinic under this amendment shall not exceed \$5,391,252.00 for State fiscal year 2004. In addition to any interest earned, TENNCARE agrees to pay the CONTRACTOR a sum sufficient to administer this amendment in

Amendment 11 (cont.)

accordance with state law. The total obligation to the CONTRACTOR under this amendment including the supplemental payment to Meharry Medical Services Foundation and/or the Meharry Dental Clinic shall not exceed \$5,501,277.60 for State fiscal year 2004. At such time that Federal Regulations allow, TENNCARE may discontinue making supplemental pool payments through the CONTRACTOR during State fiscal year 2004.

- c. Payments to the Meharry Medical Services Foundation and/or the Meharry Dental Clinic under this amendment shall not exceed \$10,000,000 for State fiscal year 2005. In addition to any interest earned, TENNCARE agrees to pay the CONTRACTOR a sum sufficient to administer this amendment in accordance with state law. The total obligation to the CONTRACTOR under this amendment including the supplemental payment to Meharry Medical Services Foundation and/or the Meharry Dental Clinic shall not exceed \$10,204,080 for State fiscal year 2005. At such time that Federal Regulations allow, TENNCARE may discontinue making supplemental pool payments through the CONTRACTOR during State fiscal year 2005.
- d. Payments to the Meharry Medical Services Foundation and/or the Meharry Dental Clinic under this amendment shall not exceed \$10,000,000 for State fiscal year 2006. In addition to any interest earned, TENNCARE agrees to pay the CONTRACTOR a sum sufficient to administer this amendment in accordance with state law. The total obligation to the CONTRACTOR under this amendment including the supplemental payment to Meharry Medical Services Foundation and/or the Meharry Dental Clinic shall not exceed \$10,204,080 for State fiscal year 2006. At such time that Federal Regulations allow, TENNCARE may discontinue making supplemental pool payments through the CONTRACTOR during State fiscal year 2006.

45. Section 2-26 shall be deleted and replaced in its entirety so that the amended Section 2-26 shall read as follows:

2-26 Processing and Payment of Critical Access Hospital Payments

Subject to the availability of State and Federal funding, the CONTRACTOR agrees to make payments to certain hospitals designated as critical access hospitals based on a schedule to be provided by TennCare. These payments are being made in accordance with the methodology approved by the Centers for Medicare and Medicaid Services, which appears as Amendment 2 to the State's Operational Protocol. The payment by the CONTRACTOR to the hospital(s) will be made within 10 calendar days of the receipt of such payment by the CONTRACTOR from TENNCARE. The CONTRACTOR may deposit these funds in the account of its choice and may retain all interest earned as compensation for providing this service. The CONTRACTOR agrees to include any correspondence requested by TENNCARE to be included with the payment and provide a written confirmation of any disbursements including the date the check was mailed and the date redeemed.

- a. Payments to the critical access hospitals under this amendment shall not exceed \$4,708,300 for State fiscal year 2003. In addition to any interest earned, TENNCARE agrees to pay the CONTRACTOR a sum sufficient to administer this amendment in accordance with state law. The total obligation to the CONTRACTOR under this amendment including the payments to the hospitals shall not exceed \$4,804,388 for State fiscal year 2003.
- b. Payments to the critical access hospitals under this amendment shall not exceed \$4,708,300 for State fiscal year 2004. In addition to any interest earned, TENNCARE agrees to pay the CONTRACTOR a sum sufficient to administer this amendment in accordance with state law. The total obligation to the CONTRACTOR under this amendment including the payments to the hospitals shall not exceed \$4,804,388 for State fiscal year 2004. At such time that Federal Regulations allow, TENNCARE may discontinue making supplemental pool payments through the CONTRACTOR during State fiscal year 2004.
- c. Payments to the critical access hospitals under this amendment shall not exceed \$4,708,300 for State fiscal year 2005. In addition to any interest earned, TENNCARE agrees to pay the CONTRACTOR a sum sufficient to administer this amendment in accordance with state law. The total obligation to the CONTRACTOR under this amendment including the payments to the hospitals shall not exceed

\$4,804,388 for State fiscal year 2005. At such time that Federal Regulations allow, TENNCARE may discontinue making supplemental pool payments through the CONTRACTOR during State fiscal year 2005.

- d. Payments to the critical access hospitals under this amendment shall not exceed \$4,708,300 for State fiscal year 2006. In addition to any interest earned, TENNCARE agrees to pay the CONTRACTOR a sum sufficient to administer this amendment in accordance with state law. The total obligation to the CONTRACTOR under this amendment including the payments to the hospitals shall not exceed \$4,804,388 for State fiscal year 2006. At such time that Federal Regulations allow, TENNCARE may discontinue making supplemental pool payments through the CONTRACTOR during State fiscal year 2006.

46. Section 2 shall be amended by adding a new Section 2-27 which shall read as follows:

2-27 Processing and Payment of Essential Hospital Payments

Subject to the availability of State and Federal funding, the CONTRACTOR agrees to make essential provider payments to certain hospitals pursuant to a schedule set forth by TENNCARE, within 14 calendar days of receipt of the required funds from the State. Payments shall be made in accordance with the methodology and payment list provided by TENNCARE from a fund established by TENNCARE and transferred to the CONTRACTOR for this purpose. The CONTRACTOR may deposit these funds in the account of its choice and may retain all interest earned as compensation for providing this service. The CONTRACTOR agrees to include any correspondence requested by TENNCARE to be included with the payment and to provide a complete accounting on an individual provider basis of all disbursements made including the date check is mailed or the transaction is made, the amount, payee, address, and date cashed. Checks and/or funds transfers issued shall be only for the amount included in the payment list provided by TENNCARE. The Contractor agrees to take all reasonable steps to cancel all outstanding checks, ninety days after issuance and any funds remaining will be returned to TENNCARE with an accounting of those not cashed. In the event that a bank subsequently processes and honors a canceled check, TENNCARE will honor the payment made by the Contractor subject to the specific amount limits in the payment list provided by TENNCARE.

- a. Upon notice by TENNCARE, the Contractor will pay each provider the Quarterly Payment Due presented in the schedule provided by TENNCARE each quarter (period covering July 1, 2005 through June 30, 2006) of the State's fiscal year. The amount of quarterly payments may vary. The actual payment amount for each quarter will be provided by TENNCARE and will be based on the disbursement methodology recommended by TENNCARE's actuaries. Disbursements to providers by the CONTRACTOR, under this amendment, shall not exceed \$100,000,000, as presented in the schedule provided by TENNCARE. In addition to any interest earned, TENNCARE agrees to pay the CONTRACTOR a sum sufficient to administer this amendment in accordance with state law. Payments to the CONTRACTOR, under this amendment, will not exceed \$102,040,816.

47. Section 2 shall be amended by adding a new Section 2-28 which shall read as follows:

2-28 Community Health Record

- a. Contractor Responsibility for Community Health Record. Effective July 1, 2005, VSHP shall receive all data to be contained in the CHR. VSHP will provide a health maintenance module within the CHR which captures individual progress toward receiving targeted preventive health interventions for their cohort (i.e. EPSDT requirements for children and youth). The module helps clinicians recognize opportunities for educational and preventative healthcare services for their patients at the point of care. VSHP will link all of this data based on an Enterprise Master Person Index (EMPI). The EMPI provides a central repository for person-centric data from a variety of contributing systems. EMPI facilitates the integrity of a single person record. The mission of the EMPI is to provide the functionality for the end-user to find the right person and the right information at the right time. Additionally, the EMPI provides a solution to identify and eliminate as many duplicate records as possible.

Amendment 11 (cont.)

- b. Community Health Record Deliverables. Effective July 1, 2005, version 1.0 of the CHR shall be available to TENNCARE for VSHP contracted providers and all enrollees assigned to BlueCare/TennCare Select. The CHR shall include the following enrollee information:
- Patient Demographics
 - Primary Care Physicians (PCPs) identified
 - Claimed visit information from claims detail
 - Medication information from claims detail
 - State immunization information
 - Lab data information from claims detail
 - Interactivity by the provider through EPSDT (TenderCare) documentation to include 16 age specific forms complying with current periodicity

c. Community Health Record Electronic Prescribing Function

Beginning no later than October 31, 2005, as a component of the Community Health Record function of TennCare Select, the Contractor shall begin making available to VSHP contracted providers the following electronic prescribing functionality to allow for prescribing medications:

- Eligibility
- Formulary information
- Drug to drug compatibility
- Drug to allergy checking
- Dose range checking based on predetermined characteristics including age, height, weight and additional attributes
- Member and provider education as regards co-pays and total costs differentials for brand names versus generic utilization
- Appropriate therapeutic substitution
- Step care progression relevant to clinical process

Effective January 1, 2006, VSHP shall make available version 1.0 of the Community Health Connection to all TennCare providers for the entire TennCare population, not to exceed 1.3 million members. Prior to January 1, 2006, VSHP shall commence comprehensive communication, marketing and outreach programs to providers to maximize the number of providers who utilize the Share Health System. VSHP shall target a 10% provider adoption rate by TennCare providers no later than the end of 1st Quarter 2006; 16% in Year 2 and 25% in Year 3.

d. Cooperation with Regional Health Information Organizations

Consistent with the state's objectives to further electronic community health record efforts more broadly, VSHP and its sub-contractors shall, in keeping with the obligations and goals of this agreement, cooperate with contracted Regional Health Information Organizations as directed by TennCare.

e. Use of Community Health Record Information

The CONTRACTOR agrees that all information, including but not limited to, studies, draft manuscripts, etc., to be used for any other purpose than to fulfill the obligations of this Contract shall be submitted to TENNCARE for review and written, expressed approval prior to its release and/or use.

48. The first paragraph of Section 4 shall be amended by adding a new sentence to the end of the existing text which shall read as follows:

For purposes of this Agreement, TENNCARE may define enrollees in specified categories for purposes of payments to the CONTRACTOR and/or enrollee eligibility for specified levels of services and benefits as well as cost share responsibilities.

Amendment 11 (cont.)

49. Section 5-1 shall be amended by adding new subparts h and i which shall read as follows:

h. Additional Payment for Specified Achievement Level of NCQA Accreditation

In addition to the fixed administrative fee specified in Section 5-1, the CONTRACTOR may obtain additional payments for the successful achievement of NCQA Accreditation.

PERFORMANCE MEASURE	MEASUREMENT	POTENTIAL PAY-OUT	PAY-OUT FORMULA	DATA SOURCE
NCQA Accreditation Status	NCQA Accreditation Status Achieved: 1. Excellent 2. Commendable 3. Accredited 4. Provisional 5. Denied	Initial Accreditation Fees that qualify as reimbursable: Application and Pre-Survey Fee, Base Survey Fee, and the additional Per Member Fee NOTE: Proof of payment to NCQA will be required for reimbursement	Reimbursed at the following rates: 1. Excellent – 100% 2. Commendable – 80% 3. Accredited – 60% 4. Provisional – 40% 5. Denied – 0 NOTE: Fees associated with resurveys within three years of the initial accreditation status determination will not be reimbursed.	NCQA Final Accreditation Status Report

Payout for reimbursable expenses shall occur within thirty (30) days of receipt by TENNCARE of proof of the CONTRACTOR's NCQA paid invoice.

i.

Effective July 1, 2005 through June 30, 2006, VSHP shall provide all services required to maintain the CHR, EPSDT documentation and reporting analytics as related to said CHR as defined above, at no additional charge to the TennCare Bureau. Subject to written notice being received by VSHP of the State's desire not to continue VSHP's obligations pursuant to providing all necessary services to maintain the CHR within sixty (60) days prior to June 30, 2006, effective July 1, 2006 through June 30, 2007, VSHP shall be reimbursed an administration fee of \$1.20 PMPM for maintaining and providing the CHR.

50. Section 5-3.a shall be amended by adding a new paragraph to the end of the existing text so that the amended Section 5-3.a shall read as follows:

a. Medical Services Payments. The CONTRACTOR shall prepare checks for payment on a periodic basis. The CONTRACTOR shall notify the State of the amount to be paid in a mutually acceptable form and substance at least 48 hours in advance of distribution of provider checks. The amount to be paid shall be reduced by the amount of third party recoveries captured in the claims processing system. The State shall release funds in the amount to be paid to providers to the CONTRACTOR. Funds shall be released within 48 hours of receipt of notice.

For each request related to payments to providers through the CONTRACTOR's claims processing system, the CONTRACTOR shall provide a claims data extract in a format and media described by TENNCARE to support the payments released to providers. The CONTRACTOR should provide a reconciliation for the total paid amounts between the funds released for payment to providers, the supporting claims data extract, and the encounter data submissions for the relevant adjudication cycle. The reconciliation should be submitted with the claims data extract.

51. Section 6-7 shall be deleted and replaced in its entirety so that the amended Section 6-7 shall read as follows:

6-7 Conflict of Interest

The CONTRACTOR warrants that during the term of this Agreement no payments shall be paid to the following:

- (1) any State or federal officer, including but not limited to
 - a. a member of the State Legislature, or
 - b. a member of Congress, or
 - c. any immediate family member of any State or federal officer; or
- (2) any State or federal employee or any immediate family member of a State or federal employee unless otherwise authorized by the Commissioner, Tennessee Department of Finance and Administration. Immediate family members may be exempted if State or federal officer or employee discloses such relationship to TENNCARE and the TennCare Oversight Committee. The applicability of this section includes, but is not limited to, any and all arrangements and/or agreements, written or verbal, that result in the CONTRACTOR making a payment or providing a gift in exchange for services or supplies.

The CONTRACTOR must certify annually by filing a TennCare Disclosure of Lobbying Activities Form (Attachment II) with TENNCARE and the TennCare Oversight Committee that the CONTRACTOR is in compliance with all state and federal laws relating to conflicts of interest and lobbying, having made diligent inquiry of all subcontractors and/or persons receiving payment or gifts from CONTRACTOR pursuant to this Agreement. This form must be signed by the Chief Executive Officer of the CONTRACTOR or his/her designee and must be received by TENNCARE and the TennCare Oversight Committee no later than December 31 of each year beginning with December 31, 2005. The certification must include any and all subcontractors, vendors, agents, providers, representatives and others with verbal or written agreements with the CONTRACTOR which receive reimbursement through this Agreement from the CONTRACTOR. The Chief Executive Officer acknowledges that he/she is responsible for ensuring that internal controls are in place to prevent and detect potential conflicts of interest and that due diligence was performed before providing certification of compliance. Any changes by the CONTRACTOR relating to the disclosure of conflicts of interest or lobbying must be disclosed to TENNCARE within five (5) business days of the date of the change. (See Section 4-12 for definitions of lobbying activities)

This Agreement may be terminated by TENNCARE if it is determined that the CONTRACTOR, its agents or employees offered or gave gratuities of any kind to any official, employee or immediate family member of an employee of the State of Tennessee, including a member of the State legislature. This Agreement may be terminated by TENNCARE if it is determined that gratuities of any kind were offered to or received by any of the aforementioned officials or employees from the CONTRACTOR, his agent, or employees.

Failure to comply with the provisions required herein shall result in liquidated damages in the amount of one-hundred ten percent (110%) of the total amount of compensation that was paid inappropriately and may be considered a breach of this Agreement as described in Section 4-2. and subject to termination of this Agreement.

The CONTRACTOR shall be responsible for maintaining adequate internal controls to detect and prevent conflicts of interest from occurring at all levels of the organization and include the substance of this clause in all agreements, subcontracts, provider agreements, and any and all agreements that result from this Agreement between CONTRACTOR and TENNCARE.

52. Section 6-8.2.2 shall be amended by adding new liquidated damages which shall read as follows:

B.4	Deadlines for Achieving NCQA Accreditation	Termination of the Agreement for Breach as described in Section 6-2 for consistent failure to meet the deadlines described in Section 2-9.6.8 of this Agreement.
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B.5	Failure to submit Audited HEDIS and CAHPS Reports Annually by June 15 th as described in Section 2-9. 6.8 and 2-10.13.4	\$250 per day for every calendar day reports are late.
B.6	Failure to submit NCQA Accreditation Report as described in Sections 2-9.6.8 and 2-10.13.6	\$500 per day for every calendar day beyond the 10 th calendar day Accreditation Status is not reported.
B.7	Failure to comply with Conflict of Interest, Lobbying, and Gratuities requirements described in Section 6-7, 6-11 or 6-12.	110% of the total amount of compensation paid by the CONTRACTOR to inappropriate individuals as described in Section 6-7, 6-11 or 6-12 and possible termination of the Agreement as described in 6-7, 6-11 or 6-12.
B.8	Failure to submit TennCare Disclosure of Lobbying Activities Form by CONTRACTOR	\$1000.00 per day that form late
B.9	Failure to comply with Offer of Gratuities constraints described in Section 6-11	110 % of the total benefit provided by the CONTRACTOR to inappropriate individuals and possible termination of the Agreement for Breach as described in 6-2 of this Agreement.

53. Sections 6-11 and 6-12 shall be deleted in their entirety and replaced by new Sections 6-11 and 6-12 which shall read as follows:

6-11. Offer of Gratuities

By signing this Agreement, the CONTRACTOR signifies that no member of or a delegate of Congress, nor any elected or appointed official or employee of the State of Tennessee, the General Accounting Office, Department of Health and Human Services, CMS, or any other federal agency has or will benefit financially or materially from this procurement. This Agreement may be terminated by TENNCARE if it is determined that gratuities of any kind were offered to or received by any of the aforementioned officials or employees from the CONTRACTOR, his agent, or employees and may result in termination of the Agreement and/or liquidated damages as provided in Section 4-8.b.2 (B.8) of this Agreement.

6-12. Lobbying

A. Definitions

- (1) Lobbying means to communicate, directly or indirectly, with any official in the legislative or executive branch, for pay or for any consideration, for the purpose of influencing any legislative action or administrative action. (T.C.A. § 3-6-102(13))
- (2) Public Official means any elected official, appointed official, or employee of:
 - (a) A federal, State or local unit of government in the U.S.
 - (b) A government corporation. (2 U.S.C.A. § 1602(15)(A) and (B))
- (3) Official in the Executive Branch means the governor, any member or the governor's staff, any member or employee of a state regulatory commission, including, without limitation, directors of

Amendment 11 (cont.)

the Tennessee regulatory authority, or any member or employee of any executive department or agency or other state body in the executive branch. (T.C.A. § 3-6-102(16))

- (4) Official in the Legislative Branch means any member, member-elect, any staff person or employee of the General Assembly or any member of a commission established by and responsible to the General Assembly or either house thereof who takes legislative action. This includes the Secretary or State, Treasurer, and Comptroller of the Treasury and any employee of such offices. (T.C.A. § 3-6-102(17))

B. The CONTRACTOR further certifies by signing this Agreement, to the best of its knowledge and belief, that Federal funds have not been used for lobbying in accordance with 45 CFR 93.100 and 31 U.S.C.A. 1352. Regardless of funding source, lobbyist compensation cannot be directly or indirectly contingent on 1) the passage or defeat of a bill related to TennCare or sister health departments, 2) the number of covered TENNCARE enrollees, 3) or the amount of TENNCARE reimbursement to a vendor. Certification from the CONTRACTOR must include the following:

- (1) No appropriated funds may be expended by the recipient of this Agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress, an elected or appointed official or employee of the State of Tennessee, the General Accounting Office, Department of Health and Human Services, CMS or any other federal agency in connection with this Agreement or subcontractors, vendors, agents, providers, representatives and others with verbal or written agreements with the CONTRACTOR which receive reimbursement through this Agreement from the CONTRACTOR.
- (2) The CONTRACTOR must certify annually by filing a TennCare Disclosure of Lobbying Activities Form (Attachment II) with TENNCARE and the TennCare Oversight Committee that the CONTRACTOR is in compliance with all state and federal laws relating to conflicts of interest and lobbying. This form must be signed by the Chief Executive Officer of the CONTRACTOR or his/her designee and must be received by TENNCARE and the TennCare Oversight Committee no later than December 31 of each year beginning with December 31, 2005. The certification must include any and all subcontractors, vendors, agents, providers, representatives and others with verbal or written agreements with the CONTRACTOR which receive reimbursement through this Agreement from the CONTRACTOR. The certification must also include signed copies of any contracts or agreements as well as a list of individual entities who have been lobbied or influenced.

Failure by the Contractor to comply with the provisions herein shall result in termination of the Contract and/or liquidated damages as provided in 4-8.b.2 (B.8, B.9, and B.10) of this Agreement.

54. Section 7-3 shall be amended by adding a new item l and renumbering the existing l as m so that the new item l shall read as follows:

- l. Effective October 1, 2005, the TennCare Bureau shall commence providing all information defined as required in the CHR for all TennCare enrollees not assigned to VSHP; and

55. Item H of Part I of Attachment I shall be amended by adding additional text to the end of the existing text so that Item H shall read as follows:

- H. Quality Monitoring/Quality Improvement Process including but not limited to:
- Annual QIPD and UMPD plus associated work plans
 - Annual evaluation
 - QIAs
- TENNCARE has thirty (30) calendar days to respond

Amendment 11 (cont.)

▪ Disease Management Programs

56. Item F, O, Z, AA, BB, and CC of Part II of Attachment I shall be deleted and replaced in their entirety so that the amended Items F, O, Z, AA, BB, and CC shall read as follows:

F	Clinical and Service Quality Improvement Activity Forms in accordance with Section 2-9.6.2	Annually, by April 15 th of each calendar year to the Office of TENNCARE
O	Monthly Activity Reporting in accordance with Section 2-10.f	Quarterly by the thirtieth (30 th) of the following month to Office of Contract Development and Compliance
Z	Quality Improvement Reports, Annual Review of the Quality Improvement Program Description, Utilization Management Program Description, associated Work Plans and Annual Evaluation of QI and UM Programs in accordance with 2-9.6 and 2-10.13.1.	Annually, by April fifteenth (15 th) to TENNCARE
AA	QIA Update Grid in accordance with 2-9.6.2 and 2-10.13.2	Within thirty (30) calendar days of the end of the quarter to TENNCARE
BB	QI Reports – PCP Assignment Reporting in accordance with 2-10.13.3	Within thirty (30) calendar days of the end of the quarter to TENNCARE
CC	All required QM/QI reports in accordance with 2-9 and 2-10	As specified, to TENNCARE

57. Part II of Attachment I shall be amended by adding new Items DD through HH and renumbering the existing items DD through HH accordingly so that the new Items DD through HH shall read as follows:

DD	Audited HEDIS and CAHPS results, including audit report/findings.	Annually by June 15 th to TENNCARE
EE	NCQA accreditation survey report	Immediately upon receipt, no later than ten (10) calendar days of notification from NCQA, to TENNCARE
FF	NCQA's annual reevaluation of accreditation status based on HEDIS score	Immediately upon receipt, no later than ten (10) calendar days of notification from NCQA to TENNCARE
GG	Notification of resurvey by NCQA	Immediately upon receipt, no later than ten (10) calendar days of notification from NCQA to TENNCARE
HH	EPSDT Report	Quarterly to TENNCARE by the end of the month following the end of each quarter

58. Attachment II shall be deleted and replaced in its entirety and the replacement shall be attached to this Amendment.

59. Attachments V, VI and VII shall be amended by adding the Spanish versions of the Sterilization, Abortion and Hysterectomy Consent Forms in their respective places and shall be attached to this Amendment.

Amendment 11 (cont.)

- 60. Attachment VIII shall be deleted and replaced in its entirety and the new Attachment VIII shall be attached to the end of this Amendment.
- 61. Attachment XI shall be deleted and replaced in its entirety and shall read as follows:

1. Out-of-Pocket Expenditures

The TENNCARE deductible for children, individuals and families shall be \$0.00. The annual TENNCARE maximum out-of-pocket expenditures described below shall apply for both uninsured and uninsurable designations. Effective August 1, 2005 (unless otherwise directed by TENNCARE), there shall be no out-of-pocket maximum amounts.

Poverty Level	Individual Maximum Annual Out-of-Pocket	Family Maximum Annual Out-of-Pocket
0%-100%	\$0.00	\$0.00
101% - 199%	\$1,000.00	\$2,000.00
200% and above	\$2,000.00	\$4,000.00

2. Copayments prior to January 1, 2003:

The following TENNCARE copayment schedule shall apply for both Uninsured and Uninsurable designations, based on the poverty level specified in TENNCARE rule 1200-13-12-.05(1)(c):

Poverty Level	Copayment Amounts
0%-100%	\$0.00
101% - 199%	\$25.00, Hospital Emergency Room (waived if admitted) \$5.00, Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care \$15.00, Physician Specialists \$5.00, Prescription or Refill \$100.00, Inpatient Hospital Admission
200% and above	\$50.00, Hospital Emergency Room (waived if admitted) \$10.00, Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care \$25.00, Physician Specialists \$10.00, Prescription or Refill \$200.00, Inpatient Hospital Admission

3. Copayment schedules effective January 1, 2003 shall be as follows:

Poverty Level	Copayment Amounts
0%-99%	\$0.00
100% - 199%	\$25.00, Hospital Emergency Room (waived if admitted) \$5.00, Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care

	\$15.00, Physician Specialists (including Psychiatrists) \$5.00, Prescription or Refill \$100.00, Inpatient Hospital Admission
200% and above	\$50.00, Hospital Emergency Room (waived if admitted) \$10.00, Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care \$25.00, Physician Specialists (including Psychiatrists) \$10.00, Prescription or Refill \$200.00, Inpatient Hospital Admission

4. **Pharmacy Copayment schedules effective August 1, 2005 (unless otherwise directed by TENNCARE) shall be as follows:**

Pharmacy Copays shall apply to all TennCare Standard enrollees as well as non-institutionalized Medicaid adults who are eligible to receive pharmacy services in the TennCare program. For dates of service on or after July 1, 2005, these pharmacy copayment amounts shall replace the pharmacy copay amounts specified in Item 3 above. All other copay amounts specified in Item 3 shall remain in effect for TennCare Standard enrollees.

Generic	\$0
Brand Name	\$3

Pharmacy Copayments do not apply to family planning services, pregnant women, enrollees in long term care institutions (including HCBS) or receiving Hospice care.

The CONTRACTOR is specifically prohibited from waiving or discouraging TENNCARE enrollees from paying the amounts described in this provision.

Changes in cost share responsibilities that are due to take effect August 1, 2005 may be postponed as a result of Waiver and/or Court negotiations. Changes should be implemented August 1, 2005 unless otherwise directed by TENNCARE.

- 62. Attachment XII, Exhibit C shall new 10 and 11 and renumbering the existing 10 through 22 accordingly
 - 10. Initial Credentialing Indicator and Date
 - 11. Recredentialing Indicator and Date
- 63. Attachment XII, Exhibit H shall be deleted and replaced in its entirety and shall be attached to the end of this Amendment.
- 64. Attachment XII, Exhibit I shall be deleted and replaced in its entirety and shall be attached to the end of this Amendment.
- 65. The term "TennCare Medical Director" shall be deleted and replaced by the term "TennCare Chief Medical Officer" throughout this Agreement.
- 66. The specified TennCare Rules and Regulation citations mentioned throughout the Agreement shall be automatically updated at such time that TennCare Rules and Regulations are appropriately promulgated and said references change.

ATTACHMENT II - DISCLOSURE OF LOBBYING ACTIVITIES

**INSTRUCTIONS FOR COMPLETION OF LOBBYING
DISCLOSURE FORM FOR THE BUREAU OF TENNCARE**

This disclosure form shall be filed with TennCare and the TennCare Oversight Committee annually by the reporting entity no later than December 31 of each year, beginning on December 31, 2005; however an ongoing duty exists to amend and update all filings. All TennCare-related lobbying relationships and/or contracts should be disclosed on a separate form. Disclosure is required if any portion of funds received under a contract, grant or other relationship with TennCare was paid to a lobbyist or lobbying entity as defined by Tenn. Code Ann. 3-6-102 and as further defined in Section 4-12 of the CRA. For those Contractors reliant on TennCare for greater than two-thirds of their total revenue in the previous fiscal year, all lobbying contracts will be presumed to be TennCare-related. This form has been designed consistent with federal regulations, 31 U.S.C. 1352 and 42 CFR 93.100. Refer to the implementing guidance provided by the Federal Office of Management and Budget for additional information.

1. Identify the type of lobbying relationship being disclosed (*e.g. ongoing, one-time*). Use a separate form for each lobbyist contract or relationship.
2. Identify the purpose of the lobbying relationship as quoted in the contractual agreement.
3. Identify the appropriate classification of this disclosure. Any material change to information previously reported should be disclosed in an amended form within five (5) business days.
4. Enter the full name, address, city, state and zip code of the reporting entity.
5. Enter the total reimbursement paid to lobbyist in the previous fiscal year.
6. Enter the full name, job title, address, city, state and zip code of the lobbying registrant engaged by the reporting entity identified in item 4.
7. Enter the full name(s) of the individual(s) performing services and include full address if different from item 6. Enter last name, first name, middle initial (MI), and job title.
8. Enter the full name(s), job title(s) of individuals lobbied, the subject matter of the lobbying activity(ies) and the total value of all gifts/remuneration received. (See Tenn.Code Ann. 3-6-102 and Section 4-12 of the CRA for a definition of relevant lobbying activities)
9. The certifying contractor or vendor Chief Executive Officer shall sign and date the affirmation, print his/her name, title, and telephone number.

ATTACHMENT II

<p>LOBBYING DISCLOSURE</p> <p>Complete this form to disclose TennCare-related* lobbying relationships entered into or existing in the previous fiscal year. Each lobbying relationship/contract requires a separate form.</p>		 <p>State of Tennessee Bureau of TennCare</p>
<p>1. Type of Relationship: <i>(e.g., ongoing, one-time)</i></p>	<p>2. Stated Purpose of the Relationship:</p>	<p>3. Report Type: a. Initial Filing b. Material Change</p> <p>For Material Change Only: Year _____ Quarter _____ Date of last Report _____</p>
<p>4. Name and Address of Reporting Entity:</p>		<p>5. Total Reimbursement Paid to Lobbyist: \$ _____</p>
<p>6. Name and Address of Lobbying Registrant: <i>(If individual, last name, first name, MI)</i></p>		<p>7. Individuals Performing Services: <i>(Including address if different from No. 6)</i></p>
<p>8. List of Individuals Lobbied: <i>(Including name, job title, subject matter of lobbying activity(ies) and total value of all gifts/remuneration received)</i></p>		
<p>9. "I hereby affirm that to the best of my knowledge my organization and its sub-contractors remain in compliance with state contractual requirements barring payment to state officials."</p> <p>Signature: _____</p> <p>Print Name: _____ Title: _____</p> <p>Telephone No.: _____ Date: _____</p>		

* Disclosure is required if any portion of a lobbying relationship relates to TennCare. For those CONTRACTORS reliant on TennCare for greater than two-thirds of their total revenue in the previous fiscal year, all lobbying contracts will be presumed to be TennCare-related.

** Attach additional sheets if necessary. Include the name of the Reporting Entity and date on each additional sheet.

Número de Medicaid del receptor

INSTRUCCIONES COMPLETE Y ADJUNTE AL FORMULARIO DE RECLAMACIÓN CUANDO ENVÍE EL RECLAMO PARA SU PAGO.

AVISO: SU DECISIÓN, EN CUALQUIER MOMENTO, DE NO SER ESTERILIZADO, NO TENDRÁ COMO CONSECUENCIA EL QUE SE LE RETIRE O SE LE NIEGUE NINGUNO DE LOS BENEFICIOS PROPORCIONADOS POR CUALQUIER PROGRAMA O PROYECTO QUE RECIBA FONDOS FEDERALES

CONSENTIMIENTO PARA ESTERILIZACIÓN

He pedido y he recibido información sobre la esterilización de

(Doctor o clínica)

Cuando pedí la información, se me dijo que la decisión de practicar la esterilización es totalmente mía. Se me dijo que podría decidir que no se me esterilice. Si decido que no se me esterilice, mi decisión no afectará mi derecho a cuidado o tratamiento en el futuro. No perderé ninguna de las ayudas y beneficios de programas que reciben fondos federales, como A.F.D.C. o Medicaid, que esté recibiendo actualmente o a los que podría tener derecho.

ENTIENDO QUE LA ESTERILIZACIÓN SE DEBE CONSIDERAR COMO PERMANENTE Y NO REVERSIBLE. HE DECIDIDO QUE NO QUIERO QUEDAR EMBARAZADA, DAR A LUZ NI ENGENDRAR NIÑOS.

Se me ha informado acerca de aquellos métodos temporales de control natal que están disponibles y que se me podrían proveer, los cuales me permitirían dar a luz o engendrar un niño en el futuro. He rechazado estas alternativas y he escogido que se me esterilice.

Entiendo que se me va a esterilizar mediante una operación conocida como

Se me han explicado las incomodidades, riesgos y beneficios relacionados con la operación. Todas mis preguntas han sido contestadas a mi entera satisfacción.

Entiendo que la operación no se llevará a cabo sino hasta que hayan transcurrido treinta días de la fecha en que firme este documento. Entiendo que puedo cambiar de opinión en cualquier momento y que mi decisión en cualquier momento de no se me practique la esterilización no tendrá como consecuencia el que se me niegue ningún beneficio de los servicios médicos que se prestan bajo programas con fondos federales.

Tengo por lo menos 21 años de edad y nací el

(Mes, día y año)

Yo, _____, por este medio doy mi consentimiento, por mi propia voluntad, para ser esterilizado por

(Doctor)

mediante un método llamado _____
Mi consentimiento caduca 180 días después de la fecha de mi firma abajo.

También doy mi consentimiento para que se entregue este documento y otros documentos sobre la operación a:

Representantes del Departamento de Salud, Educación y Bienestar (*Department of Health, Education and Welfare*) y a los empleados de programas o proyectos financiados por dicho Departamento, pero sólo para determinar si se acataron las leyes federales.

He recibido copia de este formulario.

Firma del receptor _____ Fecha _____
Hora _____ AM PM Mes/día/año

Se le solicita que provea la siguiente información, aunque no es obligatorio.

- Raza y origen étnico (por favor marque)
 - Indio Americano o Nativo de Alaska
 - Negro (sin ser de origen hispano)
 - Asiático o isleño del Pacífico
 - Hispano
 - Blanco (sin ser de origen Hispano)

DECLARACIÓN DEL INTÉRPRETE

(Si es que se ha proveído un intérprete para que asista al individuo a ser esterilizado.)

He traducido la información y consejos que fueron presentados oralmente al individuo a ser esterilizado por la persona que ha obtenido este consentimiento. También le he leído el formulario de consentimiento en el idioma _____ y le he explicado su contenido. A mi saber y entender, esta persona ha entendido esta explicación.

Firma del intérprete _____ Fecha _____

Antes de que _____ firmara
(Nombre del individuo)

el formulario de consentimiento, le expliqué la naturaleza de la operación de esterilización

el hecho de que se trata de un proceso final e irreversible, así como las incomodidades, riesgos y beneficios relacionados con él.

He informado al individuo a ser esterilizado que existen métodos alternos de control natal, los cuales son temporales. Le he explicado que la esterilización es diferente porque es permanente.

He informado al individuo a ser esterilizado que su consentimiento puede ser retirado en cualquier momento y que no perderá ningún servicio o beneficio de salud financiado con fondos federales.

A mi saber y entender, el individuo a ser esterilizado tiene al menos 21 años de edad y aparenta tener competencia mental. Esta persona ha solicitado, a sabiendas y voluntariamente, ser esterilizado y parece entender la naturaleza y consecuencias del procedimiento.

Firma de la persona que obtiene el consentimiento _____ Fecha _____

Centro

Dirección

DECLARACIÓN DEL MÉDICO

Poco antes de practicar una operación de esterilización a

Nombre del individuo a ser esterilizado _____ el _____
Fecha de la esterilización

le expliqué la naturaleza de la operación de esterilización

Especifique el tipo de operación

el hecho de que se trata de un proceso final e irreversible, así como las incomodidades, riesgos y beneficios relacionados con él.

He informado al individuo a ser esterilizado que existen métodos alternos de control natal, los cuales son temporales. Le he explicado que la esterilización es diferente porque es permanente.

He informado al individuo a ser esterilizado que su consentimiento puede ser retirado en cualquier momento y que no perderá ningún servicio o beneficio de salud financiado con fondos federales.

A mi saber y entender, el individuo a ser esterilizado tiene al menos 21 años de edad y aparenta tener competencia mental. Esta persona ha solicitado, a sabiendas y voluntariamente, ser esterilizada y parece entender la naturaleza y consecuencias del procedimiento.

Instrucciones para el uso de los párrafos finales alternativos:

Use el primero de los párrafos que siguen, excepto en el caso de parto prematuro o de cirugía abdominal de emergencia en la que la esterilización se llevó a cabo menos de 30 días tras la fecha en que el individuo firmó el formulario de consentimiento. En dichos casos, se debe usar el segundo de los párrafos que siguen. Tache el párrafo que no aplique.

(1) Han pasado al menos treinta días entre la fecha en que el individuo firmó este consentimiento, y la fecha en que se llevó a cabo la operación de esterilización.

(2) Esta esterilización se llevó a cabo menos de 30 días, pero más de 72 horas, después de la fecha en que el individuo firmó este consentimiento, debido a las siguientes circunstancias (marque el cuadro que aplique y llene la solicitud de información):

- Parto prematuro
 - Fecha esperada de alumbramiento _____
 - Cirugía abdominal de emergencia
- (describa las circunstancias)

Firma del médico

Hora de firma _____ AM PM Fecha de firma _____

DECLARACIÓN DE LA PERSONA QUE OBTUVO EL CONSENTIMIENTO

CERTIFICADO DE NECESIDAD DE ABORTOFECHA DEL SERVICIO: _____ **1** _____

Basado en mi opinión profesional, certifico que un aborto es médicamente necesario en el caso de:

Nombre Completo del Paciente: _____ **2** _____Número de Seguro Social del Paciente: _____ - **3** - _____

Por la siguiente razón:

(MARQUE UNA) 4

- Hay suficiente evidencia para creer que el embarazo es el resultado de violación o incesto.
- El aborto es médicamente necesario ya que la mujer sufre de un desorden físico, daño físico o enfermedad física, incluyendo una condición que pone en peligro su vida causada o desarrollada por el embarazo mismo que pondría a la mujer en peligro de muerte al menos que el aborto se efectuó.

DOCUMENTACION DE APOYO: 5**(POR FAVOR MARQUE TODOS LOS QUE APLICAN Y ANEXE LOS DOCUMENTOS)**

- Documentación de una agencia que ejecute la ley indicando que el paciente a hecho una denuncia creíble como una víctima de violación o incesto.
- Documentación de una agencia de salud social, El Departamento de Servicios Humanos (DHS) o una agencia de concejería (como el Centro de Crisis para Mujeres Violadas) indicando que el paciente hizo una denuncia creíble como una víctima de violación o incesto.
- Historial médico que documente la razón del aborto como una de salvación de la vida de la mujer.
- Otro (Favor de especificar): _____

DIRECCION DEL PACIENTE:**CIRUJANO QUE HARA EL ABORTO:**

_____ **6** _____

FIRMA: _____ **7** _____

NOMBRE DEL DR.: _____ **8** _____

SS# DEL DR.: _____ - _____ - _____

DIRECCION DEL DR:

MEDICAID – TÍTULO XIX
ACUSE DE RECIBO DE INFORMACIÓN SOBRE HISTERECTOMÍA
 → SIEMPRE DEBE LLENARSE ESTA SECCIÓN ←

Nombre de la receptora _____ Número de ID de Medicaid _____
 Nombre del Médico _____ Fecha de la histerectomía _____

→ SÓLO LLENE UNA DE LAS SECCIONES SIGUIENTES LLENE TODOS LOS ESPACIOS DE ESA SECCIÓN ←

SECCIÓN A: LLENE ESTA SECCIÓN EN EL CASO DE QUE LA RECEPTORA RECONOZCA RECEPCIÓN PREVIA A LA HISTERECTOMÍA

Reconozco haber recibido información, tanto oral como escrita, previamente a la operación de histerectomía, en la cual se me ha indicado que, al ser llevada a cabo la histerectomía quedará incapacitada de manera permanente para procrear.

FIRMA DEL TESTIGO	FECHA	FIRMA DEL PACIENTE	FECHA
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SECCIÓN B: LLENE ESTA SECCIÓN CUANDO APLIQUE CUALQUIERA DE LAS EXCEPCIONES SIGUIENTES

Certifico que antes llevé a cabo el procedimiento de histerectomía sobre la receptora que se indica abajo:

MARQUE

UNO

1 Le informé que esta operación la dejaría incapacitada de manera permanente para procrear. (Esta certificación es sólo para receptora con derecho retroactivo -- antes de que pueda hacerse el reembolso, este formulario debe ser acompañado de la tarjeta de Medicaid que cubre la fecha de la histerectomía, o de copia del aviso de aprobación retroactiva.)

2 Ya era estéril debido a _____

CAUSA DE LA ESTERILIDAD

3 Se le practicó la histerectomía debido a una situación que ponía en peligro su vida, la cual fue causada por _____

DESCRIBA LA SITUACIÓN DE EMERGENCIA

por lo que no pudo proporcionarse la información acerca de la esterilidad antes de la histerectomía.

FIRMA DEL MÉDICO	FECHA
------------------	-------

SECCIÓN C: LLENE ESTA SECCIÓN SÓLO EN CASO DE QUE EL RECEPTOR SEA INCOMPETENTE MENTALMENTE

Reconozco haber recibido información, tanto oral como escrita, previamente a la operación de histerectomía que se va a llevar a cabo, indicando que al ser practicada la histerectomía a la receptora nombrada arriba, ella quedará incapacitada de manera permanente para procrear.

FIRMA DEL TESTIGO	FECHA	FIRMA DEL REPRESENTANTE DE LA PACIENTE	FECHA
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DECLARACIÓN DEL MÉDICO

Afirmo que la histerectomía que practiqué a la receptora antes mencionada fue necesaria desde el punto de vista médico debido a _____

RAZÓN DE LA HISTERECTOMÍA

y que no fue hecha con fines de esterilización, y que, a mi entender, la persona a la que se le practicó la histerectomía es mentalmente incompetente. Antes de practicar la histerectomía, informé a su representante, tanto de manera oral como escrita, que la histerectomía la dejaría incapacitada de manera permanente para procrear, y que el representante de la persona ha firmado un acuse de recibo por escrito de la información precedente.

FIRMA DEL MÉDICO	FECHA
------------------	-------

Adjunte una copia al formulario de reclamación cuando envíe el reclamo para su pago. Provea copias para el paciente y para sus archivos. SE PODRÍA SOLICITAR DOCUMENTACIÓN ADICIONAL ANTES DE EFECTUAR EL PAGO.

ESTE FORMULARIO PUEDE SER REPRODUCIDO LOCALMENTE

Recommendations of the EPSDT Screening Guidelines Committee

April, 2004

Developmental/ Behavioral Surveillance and Screening

Under Federal EPSDT rules, screening visits consist of a comprehensive health and developmental history, an unclothed physical exam, vision and hearing screenings, appropriate immunizations, laboratory tests, and health education. The purpose of these visits is to identify physical, mental, or developmental problems and risks as early as possible and to link children to needed diagnostic and treatment services. To comply with these rules and provide the highest quality of care, surveillance and screening procedures should be incorporated into the ongoing health care of the child and family as part of the provision of the medical home, as defined by the AAP (RE0062 - Developmental Surveillance and Screening of Infants and Young Children).

AAP Periodicity Guidelines (American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care) call for a developmental/behavioral assessment by history and appropriate physical examination at each visit interval. If findings identify concerns, specific objective developmental testing is needed. Developmental surveillance and developmental screening are the recommended methods for early detection of problems.

Developmental surveillance has been defined as “a flexible, continuous process whereby knowledgeable professionals perform skilled observations of children during the provision of health care. The components of developmental surveillance include eliciting and attending to parental concerns, obtaining a relevant developmental history, making accurate and informative observations of children, and sharing opinions and concerns with other relevant professionals.” Pediatricians and other health care providers often use age-appropriate developmental checklists to record milestones during preventive care visits as part of developmental surveillance. Developmental screening is a brief procedure, using a standardized tool, to determine whether a child requires further and more comprehensive evaluation.

All infants and young children should be assessed for developmental delays. School-age children and adolescents should receive additional evaluation for emotional/behavioral problems. The use of standardized screening instruments improve the accuracy of developmental assessments, and such tools exist that are both efficient and effective in the pediatric office and other settings such as primary health and public health centers. Tools listed below are recommended tools and are listed by the focus of the tool and the target age range. Providers need to develop a strategy to provide periodic assessments in the context of ongoing office based primary care. It is recognized that practice setting will influence the type and frequency of assessments provided.

Amendment 11 (cont.)

Practices should maintain and update knowledge of developmental issues, risk factors, screening techniques, and community resources for consultation, referral, and intervention. This should include acquiring skills in the administration and interpretation of reliable and valid developmental screening techniques appropriate for the population served.

Besides developmental/emotional/behavioral surveillance and screening, the listing includes a specialized screen for maternal post-partum depression. Assessment for this condition should be made in the first weeks after birth, and appropriate referral initiated as needed.

The listing also includes specific screens for autistic spectrum disorders. Early detection and referral for early intervention has been shown to improve long term outcomes in this group of disorders. In addition, the prevalence of these disorders continue to increase.

Documentation of developmental/emotional/behavioral surveillance and screening should include a description of the method used, findings, and referral or treatment plans.

Developmental/Behavioral Screening Tools/Tests and Documentation Guidelines

Documentation Guidelines

Documentation should include a description of the developmental behavioral screening method. The following items should be documented in the medical record when developmental behavioral screening is done during an EPSDT encounter:

- Any parental concerns about the child's development / behavior.
- A review of major age appropriate areas of development / behavior (e.g. motor, language, social, adaptive).
- An overall assessment of development / behavior for age (e.g. normal, abnormal, needs further evaluation).
- A plan for referral and /or further evaluation when indicated.

When validated developmental screening tests are performed in addition to the preventive medicine service or other services providers can report CPT code 96110 in addition to the Preventive Medicine Service. Examples listed in CPT include the Denver II and the Early Language Milestones Survey. This service is reported in addition to Preventive Medicine and other evaluation and management or screening services (hearing, vision, and laboratory) performed during the same visit. Informal developmental checklists are considered part of the history of the preventive medicine visit, and not reported and billed separately.

Developmental Screening Instruments

The following list includes examples of developmental/behavioral screening tests approved by the EPSDT Screening Guidelines Committee for use in the EPSDT program. They have been approved and validated and used nationally. Providers who use alternative instruments should make a selection based on a similar standard of practice. These guidelines are subject to update and revision as needed.

Focus of Screen	Targeted Age Range	Name of Screen	Age Range for Screen	Description	Scoring	Accuracy	Time Frame
Parental Post-Partum Depression	6 – 8 Weeks post-natal	<i>Edinburg Postnatal Depression Scale (EPDS)</i> JL Cox, JM Holden, R Sagovsky, from British Journal of Psychiatry, June 1987, Vol. 150. User may reproduce the scale without further permission providing they respect the copyright by quoting the names of the authors, the title and the source of the paper in all reproduced copies.	6 – 8 Weeks postnatal	Developed to assist primary care health professionals to detect mothers suffering from postnatal depression. Scale consists of ten items and indicates how the mother has been feeling during the previous week; it may be usefully repeated after two weeks.	Response categories are scored 0, 1, 2 and 3 according to increased severity of the symptoms. Items marked with an asterisk are reversed scores. The total score is calculated by adding together the scores for each of the ten items.	Source article indicates that with mothers, who scored above threshold, 92.3% were likely to be suffering from a depressive illness of varying severity.	Less than five minutes
General Development (Including social language, motor, cognitive, self-help)	Birth till age nine. Generally developmental screens are indicated for older children (school age and above) only if it is suspected that a developmental problems has not been previously detected and/or diagnosed. Children beginning school and in early primary grades may benefit from	Ages & Stages (ASQ) (Formerly Infant Monitoring System) Paul H. Brookes, Publishers PO Box 10624 Baltimore, Maryland 21285. (1.800.638.3775); www.brookespublishing.com (Initial cost of \$190 for complete system [other purchase options such as questionnaire only, available]; also available on CD-ROM; but questionnaires, once purchased are reproducible and may be copied after initial	0 to 60 months	Covers 19 different age intervals. Each questionnaire contains 30 developmental items written in simple, straightforward language, with reading levels ranging from fourth through sixth grade. Each of the 19 questionnaires (for a specific age interval) covers the following areas: communication, gross and fine motor, problem solving and personal-social. Clear drawings and simple directions help parents	Single pass/fail score	Sensitivity ranges from 70% to 90% at all ages except the 4-month level. Specificity ranges from 76% to 91%	Scoring takes about 7 minutes; questionnaire can be completed in 10-20 minutes.

Amendment 11 (cont.)

Focus of Screen	Targeted Age Range	Name of Screen	Age Range for Screen	Description	Scoring	Accuracy	Time Frame
	developmental screen as a means to detect learning problems	purchase)		indicate children's skills. There are separate copyable forms of 10 to 15 items for each age range (tied to health supervision visit schedule). Can be used in mass mail-outs for child-find programs. Available in English, French, Spanish and Korean.			
		Brigance Screens. Billerica, MA: Curriculum Associates, Inc. (1985), 153 Rangeway Road, N. Billerica, MA 01862 (1.800.225.0248)	21 to 90 months	Seven separate forms, one for each 12 month range. Taps speech-language, motor, readiness and general knowledge at younger ages and also reading and math at older ages. Uses direct elicitation and observations. Acceptable as a screen, but due to extensive direct testing, used more often as a secondary screen	Cutoff and age equivalent scores	Sensitivity and specificity to giftedness and to developmental and academic problems was 70% to 82%	10 minutes (direct testing only)
		Child Development Inventories (formerly Minnesota Child Development Inventories (1992). Child Development Review Behavior Science Systems, Inc. Box 19512	Birth to 72 months	60 yes/no descriptions with separate forms for 0-18 months (Infant Development Inventory {IDI} 18-36 months. (Early Child Development Inventory {ECDI})) and 3 years to Kindergarten	A single cut-off tied to 1.5 Standard Deviations below the mean	Sensitivity was 75% or greater across studies and specificity was 70%	About 10 minutes (if interview needed)

Amendment 11 (cont.)

Focus of Screen	Targeted Age Range	Name of Screen	Age Range for Screen	Description	Scoring	Accuracy	Time Frame
		<p>Mpls., MN 55419-9998 612-850-8700 fax 360-351-1374</p> <p>Childdevelopmentreview.com</p> <p>Heidi@childdevrev.com</p>		<p><i>(Preschool Development Inventory {PDI})</i>IDI includes a developmental milestones chart for the first 21 months of life span, across five domains (social, self-help, gross and fine motor and language). Can be mailed to families, completed in waiting rooms, administered by interview or by direct elicitation</p>			
		<p>Child Development Review Child Development Review Behavior Science Systems, Inc. Box 19512 Mpls., MN 55419-9998 612-850-8700 fax 360-351-1374</p> <p>Childdevelopmentreview.com</p> <p>Heidi@childdevrev.com</p> <p>Manual, \$11, pad of 25 parent questionnaires backed with First Five Years Child Development Chart, \$11.</p>	<p>18 months to kindergarten</p>	<p>6 questions for parents and a 26 item possible behavioral and emotional problems. The chart that is included can be used as a parent interview guide or to observe and record development in five areas: social self-help, gross and fine motor, and language. Development and age norms are based on research with the Child Development Inventories (see above) problems list, backed with a First Five Years Child Development Chart. The chart can be</p>	<p>Parents' responses to the six questions and problem checklist are classified as indicating 1) No problem, 2) a Possible Problem, or 3) Possible Major Problem. The Child Development chart results are compared to age norms, and classifies as "typical: for age in all areas, or as</p>	<p>Sensitivity 68% or greater. Specificity 88%</p>	<p>5 minutes (if interview needed)</p>

Amendment 11 (cont.)

Focus of Screen	Targeted Age Range	Name of Screen	Age Range for Screen	Description	Scoring	Accuracy	Time Frame
				used for observation, as a parent interview guide, or as parent education tool. The CDR helps determine whether a child's development is "normal," "borderline," or "delayed" in five developmental areas; energy, motor symptoms, language symptoms, behavioral and emotional problems. The chart that is included can be used as a parent interview guide or to observe and record development in five areas: social self-help, gross and fine motor, and language.	"borderline" or "delayed" in one or more areas of development. Guidelines for identifying indicators of need for follow-up are described in the manual		
		<p>Denver-II Denver Developmental Materials, Inc. P.O. Box 371075 Denver, CO 80237-5075 (303) 355-4729** 1-800-419-4729 Fax* (303) 355-5622 www.denverii.com/DenverII.html Cost: Test kit, \$50; Training Manual, \$25; Test forms (pkg of 100), \$24 for English; \$28 for</p>	Birth to 6 Years	Combination of directly elicited and interviews, tapping language, personal-social gross and fine motor, but not academic or pre-academic skills. Available in English and Spanish	Pass/fail Questionable/ un-questionable	Sensitivity 80% and specificity 40% or sensitivity 40% and specificity 80% depending on how the questionable score is handled.	15 minutes for younger children, 26 minutes for older children (combination of direct and interview items)

Amendment 11 (cont.)

Focus of Screen	Targeted Age Range	Name of Screen	Age Range for Screen	Description	Scoring	Accuracy	Time Frame
		Spanish.					
		Parents' Evaluations of Developmental Status (PEDS) (1997) Ellsworth & Vandemeer Press, Ltd. P.O. Box 68164, Nashville, TN 37206 Phone: 615-226-4460; fax: 615-227-0411 http://www.pedstest.com (\$38.99)	Birth to 9 years	10 questions eliciting parents' concerns. Can be administered in waiting rooms or by interview. Available in English & Spanish. Written at the 5 th grade level. Normed in teaching hospitals and private practice.	Categorizes patients into those needing referrals, screening, counseling, reassurance, extra monitoring	Sensitivity ranged from 74% to 79% and specificity ranged from 70% to 80%.	About 2 minutes (if interview needed)
Autism & Pervasive Development Disorders (PDD)	12 months thru 36 months of age, depending upon screening tool used, and age of child at time of screen. Child should be screened once during 12 to 36 month age interval.						
		Modified Checklist for Autism in Toddlers (M-CHAT). DL Robins, D. Fein, ML Baron and JA Green. Modified Checklist for Autism in Toddlers (M-CHAT). Journal of Autism and	18 months of age	Consists of 23 yes/no questions using the original nine from the CHAT(see above). Goals of the M-CHAT are to improve the sensitivity of the CHAT and position it better for an American	Child fails the checklist when 2 or more critical items or any three items are failed. Since it is a screen, a "failing" score	Authors indicate that research is pending on sensitivity and specificity	About five minutes

Amendment 11 (cont.)

Focus of Screen	Targeted Age Range	Name of Screen	Age Range for Screen	Description	Scoring	Accuracy	Time Frame
		developmental Disorders.		audience.	is viewed as a need for further evaluation as not all children who have a failing score meet the criteria for a diagnosis on the autism spectrum		
Behavioral/ Emotional	4 through 20 Years of Age	Eyeberg Child Behavior Inventory	2 ½ to 11 year (best used to age 4)	A total of 36 short statements of common behavior problems. A score of more than 16 suggest referral for behavioral interventions. Fewer than 16 enable the measure to function as a problem list for planning in-office counseling and selecting handouts.	Single refer/non-refer score for externalizing problems (e.g. conduct, attention, aggression)	Sensitivity 80%; specificity 86%	About 7 minutes
		PEDS	Note: The PEDS can also be used to screen possible behavioral problems up to age 9	See description above under General Development			
		Pediatric Symptom Checklist (PSC) Jellinek MS, Murphy, JM, Robinson, J et al. Pediatric Symptom Checklist:	6 to 18; with modification of items (see article, can be adapted for	35 short statements of problem behaviors to which parents respond with "never," "sometimes," or "often." The PSC	<i>Single refer/non-refer score</i>	Sensitivity ranged from 80% to 95%. Specificity in all but one study was 70%	About 7 minutes (if interview needed)

Amendment 11 (cont.)

Focus of Screen	Targeted Age Range	Name of Screen	Age Range for Screen	Description	Scoring	Accuracy	Time Frame
		Screening school age children for psychosocial dysfunction. Journal of Pediatrics, 1998; 112-201-209 (the test is included in the article and in the PEDS manual); can be downloaded at: www.state.tn.us/tenncare/provider.html	ages 4 & 5)	screens for academic and emotional/behavioral difficulties.		to 100%.	
		PSC-17 Gardner W. et. al. The PSC-17: A brief symptom checklist psychosocial problem subscales: A report from PROS and ADSPN. <i>Ambulatory Child Health</i> . 1999; 5:225-236. Can be downloaded at: www.pedstest.com/links/files/psc.pdf	4 to 18	17 short statements of problem behaviors to which parents respond with "never," "sometimes," or "often." The PSC-17 screens for academic and emotional/behavioral difficulties, and includes three subscales (Aggression, Attention and Depression.)	Cut-off scores of 7 or above for aggression and attention subscales; 5 or above for depression subscale; or 15 or above for the entire 17 item screen.	Good sensitivities (.77 - .87) and specificities (.68 - .80) at the optimal cutoff points were reported in the Gardner et. al. study.	Less than 7 minutes.

- Accuracy is defined as both sensitivity and specificity
- Sensitivity = percentage of children with disabilities identified as probably delayed by a screening test.
- Specificity = percentage of children without disabilities identifies as probably normal by a screening test

* Focus of Screen:

Includes the range of problems screened (i.e. general developmental, autism and pervasive developmental disorders, post-natal depression, behavioral)

Amendment 11 (cont.)

Targeted Age Range:

Indicates within what age ranges these problems are screened.

Description:

Provides information on alternatives ways (if available) to administer measures (e.g., waiting rooms).

Scoring:

Shows general information regarding pass/fail criteria and cutoff scores

Accuracy:

Shows the percentage of patients with and without problems identified correctly.

Time Frame:

Shows the cost of professional time needed to administer and score each measure. For parent report measures, administration time reflects not only scoring of the results, but also each test's reading level and the percentage of TennCare patients with less than a high school education (who may or may not be able to complete measures due to literacy problems and will thus need office staff to read the screen to them.)

References

AAP Periodicity Guidelines (American Academy of Pediatrics recommendations for Preventive Health Care) (RE9939)

<http://www.aap.org/policy/periodicity.pdf>

Developmental Surveillance and Screening of Infants and Young Children (RE0062)

<http://www.aap.org/advocacy/archives/julyscreen.htm>

Recommendations of the EPSDT Screening Guidelines Committee

April, 2004

HEARING SCREENINGS:

- Hearing screenings performed as recommended by AAP periodicity guidelines and using acceptable methods will meet requirements for EPSDT screens.
- The goal of universal newborn hearing screening (UNHS) is to have all infants have access to hearing screening using a physiologic measure. Newborns who receive routine care have access to hearing screening during their hospital admission. Newborns in alternative birthing facilities, including home births, have access to and are referred for screening before 1 month of age. All newborns or infants who require neonatal intensive care receive hearing screening before discharge from the hospital. The components constitute UNHS.
- The goal of newborn screening is to also have all infants screened prior to discharge from hospital after birth or prior to one month; prior to 3 months refer all infants that did not pass the screen for diagnostic assessment (medical and audiological, if indicated); implement early intervention services prior to six months.
- Infants who did not pass screening should be referred for diagnostic assessment of hearing. A prompt re-screening might be substituted for immediate referral for diagnostic assessment if the clinician believes the initial screening result is likely to be false positive. Re-screening should be done within 2-4 weeks rather than waiting until the next scheduled well-child visit.
- Newborn hearing screenings are most likely to occur in hospital with results reported to the primary care provider. Acceptable methods of screening include physiologic audiological screening such as auditory brainstem response (ABR) and otoacoustic emissions (OAE) with thresholds of 30 dB HL.
- Acceptable methods of objective hearing screening include: physiologic audiological screening for newborns, such as ABR or OAE, conventional audiometry, hand-held audiometry, conditioned play audiometry (with a screening level of 20 dB HL at 500, 1000, 2000, and 4000 Hz).
- Positive screening results should lead to referral for diagnostic assessment of hearing. A prompt re-screening may be substituted for immediate referral for diagnostic assessment if the clinician believes the initial screening result is likely to be a false positive. Re-screening should be done within 2-4 weeks rather than waiting until the next scheduled well child visit.
- If there are parental concerns about hearing, at any age, then an objective screening test or diagnostic should be performed.
- Children newly entering the program (i.e. new to a practice, without medical documentation) should be brought up to date on all screening criteria.
- Physiological screening may be acceptable for older children and children who are not cooperative with conventional means (i.e. hand-held audiometry, conventional audiometry).
- Interperiodic screenings may also be conducted between recommended testing intervals.
- Progressive hearing loss may be associated with different risk factors. Please refer to references after guidelines for articles, resources that enumerate the risk indicators for progressive or late-onset hearing loss.

Recommendations for Hearing Screening		
	<i>Subjective</i>	<i>Objective</i>
Newborn	<ul style="list-style-type: none"> • Parental concern • Family history 	<ul style="list-style-type: none"> • ABR or OAE, if not performed in hospital
By 1 month	<ul style="list-style-type: none"> • Parental concern 	<ul style="list-style-type: none"> • Ear exam • If infant does not pass the hearing screen in the hospital , provide a medical evaluation and re-screen by one month or perform diagnostic testing as soon as possible prior to three months of age.
2 months	<ul style="list-style-type: none"> • Parental concern • Family history (unless previously recorded) • Response to voice and noise - parent report 	<ul style="list-style-type: none"> • Ear exam • Confirmatory pediatric audiologic diagnostic evaluation of abnormal screening result should be completed prior to 3 months of age.
4 months	<ul style="list-style-type: none"> • Parental concern • Recognizes parent's voice - parent report • Family history (unless previously recorded) 	<ul style="list-style-type: none"> • Ear exam • Infants with a confirmed hearing loss should begin audiological intervention and other early intervention services prior to six months.

Amendment 11 (cont.)

6 months	<ul style="list-style-type: none"> • Parental concern • Turns to sounds - parental report • Family history (unless previously recorded) 	<ul style="list-style-type: none"> • Ear exam • Infants with a confirmed hearing loss should begin audiological intervention and other early intervention services prior to six months.
9 months	<ul style="list-style-type: none"> • Parental concern • Response to voice and noise - parent report • Family history (unless previously recorded) 	<ul style="list-style-type: none"> • Ear exam
12 months	<ul style="list-style-type: none"> • Parental concern • Response to voice and noise - parent report • Family history (unless previously recorded) 	<ul style="list-style-type: none"> • Ear exam
15 months	<ul style="list-style-type: none"> • Parental concern • Response to voice and noise - parent report • Family history (unless previously recorded) 	<ul style="list-style-type: none"> • Ear exam
18 months	<ul style="list-style-type: none"> • Parental concern • Response to voice and noise - parent report • Family history (unless previously recorded) 	<ul style="list-style-type: none"> • Ear exam
24 months	<ul style="list-style-type: none"> • Parental concern • Response to voice and noise - parent report • Family history (unless previously recorded) 	<ul style="list-style-type: none"> • Ear exam

Amendment 11 (cont.)

3 years	<ul style="list-style-type: none"> • Parental concern 	<ul style="list-style-type: none"> • Ear exam • Hearing screen if child is cooperative.
4 years	<ul style="list-style-type: none"> • Parental concern 	<ul style="list-style-type: none"> • Ear exam • Hearing screen (if not done at 3 years)
5 years	<ul style="list-style-type: none"> • Parental concern 	<ul style="list-style-type: none"> • Ear exam • Hearing screen
6 years	<ul style="list-style-type: none"> • Parental concern 	<ul style="list-style-type: none"> • Ear exam • Hearing screen
7 years	<ul style="list-style-type: none"> • Parental and patient concern 	<ul style="list-style-type: none"> • Ear exam • Hearing screen (if not done at 6 years)
8 years	<ul style="list-style-type: none"> • Parental and patient concern 	<ul style="list-style-type: none"> • Ear exam • Hearing screen
9 years	<ul style="list-style-type: none"> • Parental and patient concern 	<ul style="list-style-type: none"> • Ear exam • Hearing screen (if not done at 8 years)
10 years	<ul style="list-style-type: none"> • Parental and patient concern. 	<ul style="list-style-type: none"> • Ear exam • Hearing screen
11 years	<ul style="list-style-type: none"> • Parental and patient concern. 	<ul style="list-style-type: none"> • Ear exam • Hearing screen (if not done at 10 years)
12 years	<ul style="list-style-type: none"> • Parental and patient concern. 	<ul style="list-style-type: none"> • Ear exam • Hearing screen
13 years	<ul style="list-style-type: none"> • Parental and patient concern 	<ul style="list-style-type: none"> • Ear exam • Hearing screen (if not done at 12 years) •

Amendment 11 (cont.)

14 years	<ul style="list-style-type: none">• Parental and patient concern.	<ul style="list-style-type: none">• Ear exam• Hearing screen (if not done at 12 or 13 years)
15 years	<ul style="list-style-type: none">• Parental and patient concern.	<ul style="list-style-type: none">• Ear exam• Hearing screen
16 years	<ul style="list-style-type: none">• Parental and patient concern.	<ul style="list-style-type: none">• Ear exam• Hearing screen (if not done at 15 years)
17 years	<ul style="list-style-type: none">• Parental and patient concern.	<ul style="list-style-type: none">• Ear exam• Hearing screen (if not done at 15, or 16 years)
18 years	<ul style="list-style-type: none">• Parental and patient concern.	<ul style="list-style-type: none">• Ear exam• Hearing screen
19 years	<ul style="list-style-type: none">• Parental and patient concern.	<ul style="list-style-type: none">• Ear exam
20 years	<ul style="list-style-type: none">• Parental and patient concern.	<ul style="list-style-type: none">• Ear exam

References

Universal Newborn Hearing Screening, Diagnosis and Intervention Guidelines for Pediatric Medical Home Providers (Flow Chart) – AAP January 2003

Joint Committee on Infant Hearing Detection and intervention Programs: Year 2000 Position Statement.

www.medicalhomeinfo.org/screening/hearing.html

Recommendations of the EPSDT Screening Guidelines Committee

April, 2004

Vision Screenings

- Screening of visual problems is important during critical age interval to detect several potential problems. These include:
 - 1) Screening of extremely prematurely born infants for Retinopathy of Prematurity (ROP), especially those who have received oxygen therapy.
 - 2) Screening for congenital cataracts and retinoblastoma at birth and through age 18 months of age.
 - 3) Screening as early as possible time for amblyopia and refractive errors. Please refer to the chart (below) for screening intervals

- Acceptable methods for screening ocular alignment include: photoscreening (preferred), unilateral cover test at 10 feet or 3 M, Random Dot E Stereotest at 40 cm (630 secs of arc). Photoscreening is not a substitute for accurate visual acuity measurement but can provide significant information about the presence of sight-threatening conditions such as strabismus, anisometropia, high hyperopia, media opacities (cataract),.
- Photoscreening results are accurate only with proper interpretation.
- Simultaneous Red Reflex Test (Bruckner Test) can detect amblyogenic conditions, such as unequal refractive errors (unilateral high myopia, hyperopia, or astigmatism), but require skilled examiners.
- Acceptable methods for screening visual acuity include: Snellen Letters, Snellen Numbers, Tumbling E, HOTV, Picture Tests, Allen Figures, LH Symbols (LEA Symbols).
- Assessments of visual acuity should be performed with an eye patch or eye taped shut, or similar procedure, in order to ensure results,
- Eye exams should entail an anterior segment inspection. The AAP/AAO Policy Statement in Pediatrics, April, 2003, should serve as the standard.
- If there are parental concern about vision , at any age, then an objective screening test or diagnostic should be performed
- Positive screening results should lead to referral for diagnostic assessment of vision. A prompt re-screening may be substituted for immediate referral for diagnostic assessment if the clinician believes his initial screening result is likely to be a false positive. Re-screening should be done within 2-4 weeks rather than waiting until the next scheduled well child visit.
- Interperiodic screenings may also be conducted between recommended testing intervals.

Recommendations for Vision Screening		
	<i>Subjective</i>	<i>Objective</i>
High Risk Prematurely Born Children; assessment to be performed by 33 weeks of gestational age or 6 weeks post-natal (whichever comes later)	N/A	<ul style="list-style-type: none"> If gestation is less than 28 weeks or weighing less than 1500 grams, child should be referred to a Pediatric Ophthalmologist for screening for Retinopathy of Prematurity (ROP) such that the first retina exam can occur by 33 weeks of gestational age or six weeks, post-natal .
Newborn		<ul style="list-style-type: none"> Eye exam: red reflex, corneal inspection. Eye exam should include the following elements: external inspection, examination of anterior segment, & red reflex
By 1 month	<ul style="list-style-type: none"> Parental concern about vision 	<ul style="list-style-type: none"> Eye exam: red reflex, corneal inspection Eye exam should include the following elements: external inspection, examination of anterior segment, & red reflex

Amendment 11 (cont.)

2 months	<ul style="list-style-type: none"> • Parental concern about vision 	<ul style="list-style-type: none"> • Eye exam: red reflex, corneal inspection Eye exam should include the following elements: external inspection, ocular motility, examination of pupils, & red reflex • Fixes on face, follows with eyes
4 months	<ul style="list-style-type: none"> • Parental concern about vision 	<ul style="list-style-type: none"> • Eye exam: red reflex Eye exam should include the following elements: external inspection, ocular motility, examination of pupils, & red reflex • Fixes and follows each eye

	<i>Subjective</i>	<i>Objective</i>
6 months	<ul style="list-style-type: none"> • Parental concern about vision 	<ul style="list-style-type: none"> • Eye exam: red reflex Eye exam should include the following elements: external inspection, ocular alignment and motility, examination of pupils, & red reflex • Fixes and follows each eye
9 months	<ul style="list-style-type: none"> • Parental concern about vision 	<ul style="list-style-type: none"> • Eye exam: red reflex Eye exam should include the following elements: external inspection, ocular motility and alignment, examination of pupils, & red reflex • Fixes and follows each eye

Amendment 11 (cont.)

12 months	<ul style="list-style-type: none"> • Parental concern about vision 	<ul style="list-style-type: none"> • Eye exam • Fixes and follows each eye
15 months	<ul style="list-style-type: none"> • Parental concern about vision • Can see small objects 	<ul style="list-style-type: none"> • Eye exam
Recommendations for Vision Screening		
	<i>Subjective</i>	<i>Objective</i>
18 months	<ul style="list-style-type: none"> • Parental concern about vision • Can see small objects 	<ul style="list-style-type: none"> • Eye exam
24 months	<ul style="list-style-type: none"> • Parental concern about vision • Can see small objects 	<ul style="list-style-type: none"> • Eye exam. • Ocular alignment, beginning at age 2 years. Children should have this screening done one time by age 6 if not performed at a prior age interval.
3 years	<ul style="list-style-type: none"> • Parental concern about vision • Can see small objects 	<ul style="list-style-type: none"> • Eye exam • Ocular alignment, beginning at age 2 years. Children should have this screening done one time by age 6 if not performed at a prior age interval. • Visual acuity (should be obtained as early as cooperation and valid results can be obtained.)

Amendment 11 (cont.)

4 years	<ul style="list-style-type: none"> • Parental concern about vision 	<ul style="list-style-type: none"> • Eye exam. • Visual acuity if not done at 3 years. • Ocular alignment, beginning at age 2 years. Children should have this screening done one time by age 6 if not performed at a prior age interval.
5 years	<ul style="list-style-type: none"> • Parental concern about vision 	<ul style="list-style-type: none"> • Eye exam • Ocular alignment, beginning at age 2 years. Children should have this screening done one time by age 6 if not performed at a prior age interval. • Visual acuity (if not done at 3 or 4 years)
6 years	<ul style="list-style-type: none"> • Parental concern about vision 	<ul style="list-style-type: none"> • Eye exam • Visual acuity • Ocular alignment, beginning at age 2 years. Children should have this screening done one time by age 6 if not performed at a prior age interval.
7 years	<ul style="list-style-type: none"> • Parental and patient concern about vision 	<ul style="list-style-type: none"> • Eye exam • Visual acuity testing (if not done at 6 years)
8 years	<ul style="list-style-type: none"> • Parental and patient concern about vision 	<ul style="list-style-type: none"> • Eye exam • Visual acuity testing
9 years	<ul style="list-style-type: none"> • Parental and patient concern about vision 	<ul style="list-style-type: none"> • Eye exam • Visual acuity testing if not done at 8 years.

Amendment 11 (cont.)

10 years	<ul style="list-style-type: none"> • Parental and patient concern about vision 	<ul style="list-style-type: none"> • Eye exam. • Visual acuity
11 years	<ul style="list-style-type: none"> • Parental and patient concern about vision 	<ul style="list-style-type: none"> • Eye exam. • Visual acuity (if not done at 10 years)
12 years	<ul style="list-style-type: none"> • Parental and patient concern about vision 	<ul style="list-style-type: none"> • Eye exam • Visual acuity
13 years	<ul style="list-style-type: none"> • Parental and patient concern about vision 	<ul style="list-style-type: none"> • Eye exam. • Visual acuity if not done at age 12.
14 years	<ul style="list-style-type: none"> • Parental and patient concern about vision 	<ul style="list-style-type: none"> • Eye exam • Visual acuity testing (if not done at 12 or 13)
15 years	<ul style="list-style-type: none"> • Parental and patient concern about vision 	<ul style="list-style-type: none"> • Eye exam • Visual acuity testing
16 years	<ul style="list-style-type: none"> • Parental and patient concern about vision 	<ul style="list-style-type: none"> • Eye exam • Visual acuity testing (if not done at 15 years)/should be done for purpose of ensuring drivers license
17 years	<ul style="list-style-type: none"> • Parental and patient concern about vision 	<ul style="list-style-type: none"> • Eye exam • Visual acuity (if not done at 15 or 16 years) •

Amendment 11 (cont.)

18 years	<ul style="list-style-type: none"> • Parental and patient concern about vision 	<ul style="list-style-type: none"> • Eye exam. • Visual acuity
19 years	<ul style="list-style-type: none"> • Parental and patient concern about vision 	<ul style="list-style-type: none"> • Eye exam • Visual acuity if not done at 18 years.
20 years	<ul style="list-style-type: none"> • Parental and patient concern about vision 	<ul style="list-style-type: none"> • Eye exam • Visual acuity if not done at 18 or 19 years.

References

Eye Examination in Infants, Children, and Young Adults by Pediatricians, Policy Statement, American Academy of Pediatrics, American Association of Certified Orthoptists, American Association for Pediatric Ophthalmology and Strabismus, American Academy of Ophthalmology, PEDIATRICS, Vol. 111, No. 4, April 2003.

ATTACHMENT XII, EXHIBIT H –QUALITY IMPROVEMENT REPORTS

SAMPLE GRID

MCO NAME: REPORTING PARTY: TELEPHONE #:							Reporting Period																
							QTR 3	QTR 4	QTR 1	QTR 2													
							(Please Circle)																
QI Activity	Indicator	Scope	Objective	Bench-Mark	Goals	Responsible Reporting Party	2005/06 Reporting Frequency																
							3rd QTR			4th QTR			1st QTR			2nd QTR							
							J	F	M	A	M	J	J	A	S	O	N	D					
Administration	Approval of written QI Program Description, UM Program Description, Work Plans and QI Evaluation	MCO care delivery system	To assure approval of the QI Program Description, UM Program Description, QI Work Plan and QI/UM Evaluation	N/A	N/A				X														
	Quarterly Report to the MCO Governing Body and TENNCARE	MCO care delivery system	To review key indicators that monitor the delivery of quality care and services by the MCO (HEDIS and CAHPS data to be reported in July)	N/A	N/A		X			X			X				X						
	MCO Committee Meeting Schedule	MCO care delivery system	To assure MCO committee meetings (QI, Credentialing, UM, etc.) occur as scheduled and are documented appropriately.	N/A	N/A		X			X			X				X						
	GEO Access Analysis	PCP and MCO identified specialists	To evaluate the accessibility of providers for existing members	N/A	N/A		X			X			X				X						
	MCO Strategic Plan	MCO care delivery system	To provide a vehicle by which to monitor the completion of major business objectives, milestones, and barriers to success	N/A	N/A					X													
Credentialing	Initial Cedentialing	Prospective MCO providers	To complete initial credentialing process NCQA credentialing time frames				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Recredentialing	Existing MCO providers	To complete the recredentialing process by NCQA recredentialing time frames				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Amendment 11 (cont.)

	Controlling High Blood Pressure	Enrolled members 46-85 years of age who had a DX of HTN	To determine the percentage of enrolled members 46-85 years of age with a DX of HTN and whose BP was adequately controlled (\leq 140/90) during the measurement year.								X		
	Beta Blocker Treatment after a Heart Attack	Enrolled members 35 years of age and older who were hospitalized and discharged alive from 1/1 to 12/24 of the measurement year with a DX of AMI and received an ambulatory Rx for beta blockers upon discharge.	To assess whether appropriate follow-up care has been rendered to members who suffer a heart attack							X			

Amendment 11 (cont.)

<p>Persistence of Beta Blocker Treatment after a Heart Attack</p>	<p>Enrolled members 35 years of age and older who were hospitalized and discharged alive from 7/1 of the year prior to the measurement year to 6/30 of the measurement year with a DX of AMI and who received persistent beta blockers treatment.</p>											
<p>Cholesterol Management After Acute Cardiovascular Event</p>	<p>Enrolled members 18-75 years of age as of 12/31 of the measurement year who were discharged alive in the year prior to the measurement year for AMI, CABG or PTCA with evidence of LDL-C</p>	<p>To determine the percentage members 18-75 years of age as of 12/31 of the measurement year who were discharged alive in the year prior to the measurement year for AMI, CABG or PTCA with evidence of well controlled cholesterol. (<130mg/dL; <100 mg/dL)</p>							<p>X</p>			

Amendment 11 (cont.)

		control below specified thresholds.										
	Comprehensive Diabetes Care	Enrolled members 18-75 years of age with diabetes, Type 1 or 2 who had each of the following: HbA1c tested, HbA1c poorly controlled (>9.0%, Retinal eye exam, LDL-C screening, LDL-C controlled, Nephropathy monitored.	To delay or prevent the complications of diabetes						X			

Amendment 11 (cont.)

	Disease Management Program II	MCO Members with chronic conditions	To identify members and actively intervene to assist both members and providers in managing chronic conditions, to improve the health status of the members				X			X		X			X	
Methodology	Inter-rater reliability	MCO nurse and physician reviewers	To assure high levels of reliability between nurse reviewers and physician reviewers in utilization and quality management													
UM	Prior Authorization Call Reporting 1. Call Answer Timeliness 2. Call Abandonment Rate	All attempts by provider/staff to access the prior auth line	To reduce average Call Answer Timeliness <30 seconds to get a live voice and the call abandon rate to < 5%		CAT: <30 Sec & CAB: <5%		X			X		X			X	
	Scientific medical technology review. Review is ongoing	New Technologies or new applications of established technologies and obsolete technologies	To provide a consistent, efficient systematic process for assessment of technology and a mechanism for annual re-review of existing assessments	N/A	N/A											

Amendment 11 (cont.)

	Under/over-utilization	Primary Care Physician, Specialty Care Physician, IP, ED, etc.	To identify potential under/over utilization trends within the participating provider network and to initiate appropriate actions when performance falls below established standards	N/A	N/A														
	UM Medical Necessity Criteria - Annual Approval	MCO membership	To provide a mechanism for updating the MCO's review of criteria on an annual basis	N/A	N/A														
Pharmacy	Controlled Substance Audit	Contracted providers	To identify potential adverse drug reactions and drug/drug interactions regarding controlled substance prescriptions; to intervene with PCPs and specialists on controlled substance prescribing patterns; and to intervene with members when appropriate (CM)				X	X	X	X	X	X	X	X	X	X	X	X	X
Service	Service QIA I									X						X			
	Service QIA II									X						X			

Amendment 11 (cont.)

Member Services Call Reporting 1. Call Answer Timeliness 2. Call Abandonment Rate	All attempts by callers to access Member Services	To reduce average Call Answer Timeliness <30 seconds to get a live voice and the call abandon rate to < 5%		CAT: <30 Sec & CAB: <5%		X			X			X			X		
Average days to close: Inquires	Member Inquires	To monitor the timeliness of resolution (aging) of customer inquires				X			X			X			X		
Appeal Overtum Rate	Medicaid appeals overturned by the MCO	To reduce the number of appeals overturned by the MCO through the identification and elimination of inappropriate denials				X			X			X			X		
Top Three Reasons for Appeals	MCO members & network providers	To monitor the top reasons for member & provider appeals				X			X			X			X		
Provider Appointment Availability Measure: 1. Initial Appointment Routine Health Assessment (3 weeks) 2. Urgent Problem (within 48 hours)	Primary Care Physician offices	Evaluate access to Primary Care network using MCO access standards										X					
Provider Availability After Hours/Weekend	Primary Care Providers	Monitor member access to emergent care 24 hours/day				X			X			X			X		
Wait Time not to exceed 45 minutes for non-urgent care	Primary Care Providers	To monitor member wait time in provider offices, not to exceed 45 minutes										X					

Amendment 11 (cont.)

			and screenings (including EPSDT).																	
	Quarterly Provider Newsletters	MCO Contracted Providers	To update providers on MCO initiatives, communicate pertinent information to contracted providers.				X			X			X				X			

Key:
X = Reporting Frequency
NA = Not Applicable
C = Completed
B = Barrier (A brief narrative of barriers encountered and action plan with revised date of completion should accompany this report.)

ATTACHMENT XII, EXHIBIT H.2 – PCP Assignment Reporting

MCO NAME: REPORTING PARTY: TELEPHONE # :		REPORTING PERIOD:			
		QTR 1	QTR 2	QTR 3	QTR 4
		(Please circle)			
QTR	Numerator: Enrollees not Assigned to a PCP within 30 days of enrollment by Grand Region during the reporting period	Denominator: Total number of new enrollees in the Grand Region during the reporting period		Rate	
1/1-3/31					#DIV/0!
4/1-6/30					#DIV/0!
7/1-9/30					#DIV/0!
10/1-12/31					#DIV/0!

ATTACHMENT XII, EXHIBIT H.3 – Quarterly EPSDT Report

**INSTRUCTIONS FOR COMPLETING THE
REVISED 2005 EPSDT REPORT**

The Bureau of TennCare Division of Quality Oversight has revised the EPSDT reporting format in order to more clearly understand the efforts managed care contractors (MCCs) are making to improve the TennCare EPSDT screening rates. By comparing and contrasting the information provided in the revised reporting format, the Division of Quality Oversight will identify best practices and opportunities for improvement within the processes.

The instructions below provide clarification and examples specific to each section of the report. The requested information for each section is reiterated. The relevant clarifications and examples follow each reporting requirement.

REPORTING REQUIREMENTS:

A. Frequency and Submission of the EPSDT Report:

The completed report must be submitted to TENNCARE by the end of the month following the end of the reporting quarter.

Timeframes Covered by the Reports	Reporting Due Dates
1st Quarter, January 1st through March 31st	April 30th
2nd Quarter, April 1st through June 30th	July 31st
3rd Quarter, July 1st through September 30th	October 31st
4th Quarter, October 1st through December 31st	January 31st

The completed electronic format of the report must be submitted via e-mail (INSERT E-MAIL ADDRESS) in addition to a hard copy accompanied by the supporting documentation. An attestation to the accuracy and truthfulness of the report must be signed and dated by the Medical Director and the Chief Executive Officer of the MCC.

The MCC must provide contact information for a single individual who will be responsible for answering questions, or providing clarification, regarding the information submitted. E-mail and telephone contact information for the assigned individual should be listed in the appropriate section of the reporting form.

B. Specific Instructions for Completing the Report by Sections:

Initial Information:

- Give the complete, legal company name
- Fully complete the report contact information
- Check the appropriate box associated with the quarter for which information is being reported.

Section I, EPSDT Outreach Occurring in the Reporting Quarter:

Place an "X" in all applicable boxes within the Table provided.

EXAMPLE:

Specific Outreach	Check Applicable Boxes
Member Handbook	X

Amendment 11 (cont.)

Newsletter	X
Reminders Prior to Screening Dues Dates	
Reminders of Overdue Screening Dates	X
Follow-up For Enrollees, eligible for EPSDT, who have not received services within a year	X
Outreach to Pregnant Women advising them of the availability of EPSDT Services for their children	X
Assistance offered to pregnant women in scheduling a timely prenatal Appointment	X
Other EPSDT Related Outreach (List by name and describe below as indicated)	

Provide a brief narrative describing the key elements of each EPSDT outreach to enrollees which has occurred in the reporting quarter, include elements such as:

- Rationale behind outreach, why selected, relevance to the population
- Specific population targeted; i.e., all parents/guardians of children under two years of age
- Focused message; specific information/message communicated to the target population; i.e., screening and immunization schedule for the first two years of life and phone number of the child’s assigned primary care provider.
- Components of the outreach; i.e., letter followed by telephone call.

If a specific methodology is in place for contacting members regarding overdue screenings, please provide the specific order of contact attempts, i.e., telephone followed by mailing:

- Supply flow chart if necessary to augment written description

Please provide any metrics associated with the outreach and the frequency of analysis:

- Is the impact of an outreach measured? i.e., comparison annually of EPSDT screening rates for a specific age group, such as < two years of age, pre and post implementation
- Survey to enrollees who went to screenings after receiving an intervention to see if that was why they went

Describe any opportunities for improvement identified and subsequent changes made to the specific outreach programs:

EXAMPLE:

- An opportunity for improvement is identified; i.e., the screening reminders were being mailed one month prior to screening due dates. There was insufficient time for parents/guardians to receive the mailings and make the appointments prior to the screening dues dates.
- Subsequent change made to the outreach program; i.e., the reminders are mailed six weeks prior to the screening due date.

Please provide a sample of the specific outreach materials/mailings/telephone scripts where applicable:

- Newsletters with the applicable article(s) hi-lighted
- Samples of screening reminder card(s)
- Notification forms used for overdue screenings
- Other examples of materials utilized

(This area will expand to accommodate data entry): Please take the space necessary to accurately describe the outreach. The document will expand to your requirements, rather than limiting you to a preset number of lines within the field.

Section II, EPSDT Eligible Enrollees in Care/Case Management Programs

Please list the specific care/case management programs in which EPSDT eligibles are enrolled:

- Programs may be disease specific such as pediatric asthma, sickle cell disease or diabetes
- Programs may be the case management of enrollees with comorbidities, or those who are seriously and chronically ill

Define the targeted population:

- Please give the specific information which qualifies an enrollee for inclusion in the program such as:
 - a diagnoses of asthma (give current procedural terminology (CPT) codes), with two or more emergency department visits or an inpatient hospitalization within the past twelve months, or
 - a diagnoses of diabetes with an HbA1c of 8 or greater
 - individuals incurring greater than \$50,000.00 in medical bills in a twelve month period

Give the length of time each program has been operational:

- Determine the difference in months between the date the program was operational (individuals contacted, enrolled and interventions in place) and the last day of the reporting quarter.

Provide the number of EPSDT eligibles enrolled in each program during the reporting quarter:

- List the number of enrollees in each program who are under twenty-one years of age

Please include the average number of contacts per enrollee, per program:

- Divide the overall number of contacts made specific to each program by the number of enrollees in that program to determine the average number of contacts per enrollee, per program

Provide a brief narrative describing the specific programs listed above: Include the following information:

- Rationale behind each, why implemented, relevance to the population, high-volume or high-risk
- Specific goals of the program; i.e., reduce HbA1c's to 6 or less of the identified diabetic population. Reduce emergency department and inpatient admissions for asthmatics while increasing use of inhaled corticoid steroids and other controller medications. Coordinate the care of individuals with significant comorbidities
- Include the specific components of each program (outreach)
- Include the metrics for each program, the baseline measurement, goals and date of remeasure. The overall metrics of the program will be acceptable. EPSDT specific calculations are not required, if that information is not readily available.

(This area will expand to accommodate data entry): Please take the space necessary to accurately describe the outreach. The document will expand to your requirements, rather than limiting you to a preset number of lines within the field.

Section III, EPSDT Well Child Screening Information

The total number of EPSDT Well Child Screening encounters received during the reporting quarter:

- Utilize the CPT and ICD-9 codes specific to well child screenings to determine this number (please see Attachment A)

The number of overdue EPSDT Well Child Screenings identified during the reporting quarter:

- Individuals that were determined to be eligible who have fallen behind on their screening schedule as of the end of the reporting quarter.

Section IV. Provider Outreach

Is there a mechanism in place to notify primary care providers of EPSDT eligibles who have overdue well child screenings?

- Answer YES or NO, Circle One, the appropriate answer

If the answer is YES, please give a brief description of each outreach, including the frequency of provider contact.

- Describe the method of contact; i.e., facsimile transmission or mailing
- List the frequency of contact; i.e., weekly, monthly or quarterly

List and briefly summarize all EPSDT related provider education which occurred during the reporting quarter. Please provide a sample of the educational materials/information to accompany the report:

- Newsletters with the applicable article(s) hi-lighted
- Notification forms used for overdue screenings, mailings or facsimile transmissions
- Other examples of materials utilized

(This area will expand to accommodate data entry): Please take the space necessary to accurately describe the outreach. The document will expand to your requirements, rather than limiting you to a preset number of lines within the field.

Section V. Coordination with Other Agencies

Please identify agency and provide a sample of coordination materials/information which occurred during the reporting quarter.

EXAMPLE:

- Head Start; include a sample of materials/information
- WIC; include a sample of materials/information
- Health Department; include a sample of materials/information
- Day Care Licensing; include a sample of materials/information

ATTACHMENT XII, EXHIBIT H.3 – Quarterly EPSDT Report

QUARTERLY EPSDT REPORT

Managed Care Company (MCC): _____

Report Contact: _____
 NAME TITLE
 TELEPHONE # E-MAIL ADDRESS

Reporting Quarter (Check Appropriate Box):

1 st Quarter of 2005	2 nd Quarter of 2005	3 rd Quarter of 2005	4 th Quarter of 2005
January 1 st through March 31 st	April 1 st through June 30 th	July 1 st through September 30 th	October 1 st through December 31 st

I. EPSDT Outreach Occurring in the Reporting Quarter:

Place an "X" in the appropriate boxes for enrollee outreach which occurred in the reporting quarter:

Specific Outreach	Check Applicable Boxes
Member Handbook	
Newsletter	
Reminders Prior to Screening Dues Dates	
Reminders of Missed Screening Dates	
Follow-up For Enrollees, eligible for EPSDT, who have not received services within a year	
Outreach to Pregnant Women advising them of the availability of EPSDT Services for their children	
Assistance offered to pregnant women in scheduling a timely prenatal Appointment	
Other EPSDT Related Outreach (List by name and describe below as indicated)	

Provide a brief narrative describing the key elements of each EPSDT outreach to enrollees which has occurred in the reporting quarter. If a specific methodology is in place for contacting members regarding missed screenings, please provide the specific order of contact attempts, i.e., telephone followed by mailing. Please provide any metrics associated with the outreach and the frequency of analysis. Describe any opportunities for improvement identified and subsequent changes made to the specific outreach programs. Please provide a sample of the specific outreach materials/mailings/telephone scripts where applicable. (This area will expand to accommodate data entry):

ATTACHMENT XII, EXHIBIT H.3 – Quarterly EPSDT Report (cont.)

II. EPSDT Eligible Enrollees in Care/Case Management Programs

Please list the specific care/case management programs in which EPSDT eligibles are enrolled. Define the targeted population and give the length of time each program has been operational. Provide the number of EPSDT eligibles enrolled in each program during the reporting quarter. Please include the average number of contacts per enrollee, per program.

Specific Program	Targeted Population	Date Program was Operational	Number of EPSDT Eligibles Enrolled During the Reporting Quarter	Average Number of Contacts Per EPSDT Enrollee Participating in the Program

Provide a brief narrative describing the specific programs listed above *(This area will expand to accommodate data entry)*:

III. EPSDT Well Child Screening Information

- a. The total number of EPSDT Well Child Screening encounters received during the reporting quarter: _____
- b. The number of missed EPSDT Well Child Screenings identified during the reporting quarter: _____

IV. Provider Outreach

- a. Is there a mechanism in place to notify primary care providers of EPSDT eligibles who have missed well child screenings? YES NO

Circle One
- b. If the answer to “a” is YES, please give a brief description of each outreach, including the frequency of provider contact. Please provide a sample of each outreach to accompany the report *(This area will expand to accommodate data entry)*:
- c. List and briefly summarize all EPSDT related provider education which occurred during the reporting quarter. Please provide a sample of the educational materials/information to accompany the report *(This area will expand to accommodate data entry)*:

ATTACHMENT XII, EXHIBIT H.3 – Quarterly EPSDT Report (cont.)

V. Coordination with Other Agencies

Please identify the specific agency or agencies and provide a sample of the materials/information utilized in the coordination efforts during the reporting quarter (*This area will expand to accommodate data entry*):

ATTESTATION:

I attest the information contained within this report is true and correct.

Signature, Chief Medical Officer

Date

Signature, Chief Executive Officer

Date

ATTACHMENT XII, EXHIBIT I – MONTHLY ACTIVITY REPORT

ATTACHMENT XII, EXHIBIT I
Instructions for Completing the Monthly Activity Report

The following definitions should be used for the purpose of completing the Monthly Activity Report.

- Definitions for reporting Member statistics:

Abandoned Call: A call in the Member Services telephone line queue that is terminated by the caller before reaching a Member Services Representative.

Call Abandonment Rate: The number of calls abandoned by the caller or the system before being answered by a live voice. Divided by the number of calls received by the MCO member services call center as (during member services open hours of operation) during the measurement period. Calls where the member called directly into member services or selected a member services option and was put in the call queue

Call Answer Timeliness: The number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the CONTRACTOR's member services call center(s) (during member services open hours of operation) during the measurement period. Calls where the member called directly into member services or selected a member services option and was put in the call queue. Refer to NCQA HEDIS Technical Specifications for further clarification and changes.

Average Time to Answer: The average time that callers waited in the Member Services telephone queue that were during normal business hours before speaking to a Member Services Representative, report in minutes: seconds (e.g. one minute and twenty-five seconds should be reported as 1:25).

- HEALTH SERVICES CALL REPORTING:

Abandoned Call: A call in the Health Services Prior Authorization line queue that is terminated by the caller before reaching a Health Services Representative.

Provider Call Abandonment Rate: The number of calls abandoned by the caller or the system before being answered by a live voice. Divided by the number of calls received by the CONTRACTOR's health services call center as (during open hours of operation) during the month. Calls where the provider called directly into health services or selected a health services option and was put in the call queue.

Provider Call Answer Timeliness: The number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the CONTRACTOR's health services call center(s) (during hours of operation) during the quarter. Calls where the provider called directly into health services or selected a health services option and was put in the call queue. Please include detailed rate calculation

The average wait time spent in queue for providers requesting prior authorization

Number of provider complaints received, either in writing or by phone during the month.

- CLAIMS PAYMENT TIMELINESS:

Timeliness of Clean and Unclean Claims Processing: Number of claims processed and, if appropriate, paid within 60 days of receipt divided by the number of all claims processed (for calculation date of receipt counts as day zero)

ATTACHMENT XII, EXHIBIT I
Monthly Activity Report

MCO Name: _____

For the Month Ending: _____

MEMBER SERVICES CALL REPORTING

- | | |
|--|--|
| A. Number of Member Phone Calls Received | Total Number |
| B. Call Abandonment Rate: The number of calls abandoned by the caller or the system before being answered by a live voice. Divided by the number of calls received by the CONTRACTOR's member services call center as (during member services open hours of operation) during the month. Calls where the member called directly into member services or selected a member services option and was put in the call queue. | _____
(% of calls abandoned) |
| C. Approximate Phone Queue Waiting Time for Member Response | _____
Report in minutes: seconds |
| D. Call Answer Timeliness: The number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the CONTRACTOR's member services call center(s) (during member services open hours of operation) during the month. Calls where the member called directly into member services or selected a member services option and was put in the call queue. Please include detailed rate calculation. | _____
(% of calls answered within 30 seconds) |

HEALTH SERVICES CALL REPORTING

- | | |
|--|--|
| A. Number of Provider Phone Calls for Prior Authorizations | Total Number |
| B. Provider Call Answer Timeliness: The number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the CONTRACTOR's health services call center(s) (during hours of operation) during the month. Calls where the provider called directly into health services or selected a health services option and was put in the call queue. Please include detailed rate calculation. | _____
(% of calls answered within 30 seconds) |
| C. The average wait time spent in queue for providers requesting prior authorization. | _____
Report in minutes: seconds |
| D. Provider Call Abandonment Rate: The number of calls abandoned by the caller or the system before being answered by a live voice. Divided by the number of calls received by the CONTRACTOR's health services call center as (during open hours of operation) during the | _____
(% of calls abandoned) |

month. Calls where the provider called directly into health services or selected a health services option and was put in the call queue.

E. Number of provider complaints received, either in writing or by phone during the month.

_____ Total Complaints

PROVIDER COMPLAINTS

A. Number of Provider Complaints, received in Writing or by Phone

CLAIMS PAYMENT TIMELINESS

A. Percentage of claims processed within sixty (60) days

All of the provisions of the original Agreement not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective July 1, 2005 or as of the date it is approved by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

BY: M. D. Goetz, Jr.
M. D. Goetz, Jr.
Commissioner

DATE: 6/24/2005

VOLUNTEER STATE HEALTH PLAN, INC.

BY: Ronald E. Harr
Ronald E. Harr
President and Chief Executive Officer

DATE: June 22, 2005

APPROVED BY:

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

BY: M. D. Goetz, Jr. /PW
M. D. Goetz, Jr.
Commissioner

DATE: JUL - 1 2005

APPROVED BY:

**STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY**

BY: John G. Morgan
John G. Morgan
Comptroller

DATE: 7/15/05

CONTRACT SUMMARY SHEET

RFS Number:	318.66-026	Contract Number:	FA-02-14632-10
State Agency:	Department of Finance and Administration	Division:	Bureau of TennCare

Contractor	Contract Identification Number
VSHP (TennCare Select)	<input type="checkbox"/> V- <input type="checkbox"/> C-

Service Description

Managed Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medicaid Population

Contract Begin Date	Contract End Date
7/1/2001	12/31/2005

Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66	532	134	11	<input type="checkbox"/> STARS		
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)	
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$	18,599,868.48
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$	33,079,942.80
2004	\$ 25,125,990.72	\$ 38,364,165.90			\$	63,490,156.62
2005	\$ 58,007,447.00	\$ 58,007,447.00			\$	116,014,894.00
2006	\$ 27,667,750.00	\$ 27,667,750.00			\$	55,335,500.00
Total:	\$ 133,342,244.35	\$ 153,178,109.55			\$	286,520,353.90

CFDA# 93.778 Title XIX Dept. of Health & Human Svcs.	Check the box ONLY if the answer is YES:
---	---

State Fiscal Contract	
Name: Dean Daniel	Is the Contractor a SUBRECIPIENT? (per OMB A-133)
Address: 729 Church Street	Is the Contractor a Vendor? (per OMB A-133)
Phone: Nashville, TN (615)532-1362	Is the Fiscal Year Funding STRICTLY LIMITED?
Procuring Agency Budget Officer Approval Signature	Is the Contractor on STARS?
Scott Pierce 	Is the Contractor's FORM W-9 ATTACHED?
	Is the Contractor's Form W-9 Filed with Accounts?

COMPLETE FOR ALL AMENDMENTS (only)			Funding Certification	
	Base Contract & Prior Amendments	This Amendment ONLY	Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.	
CONTRACT END DATE:	12/31/2004	12/31/2005		
FY: 2002	\$ 18,599,868.48			
FY: 2003	\$ 33,079,942.80			
FY: 2004	\$ 63,490,156.62			
FY: 2005	\$ 110,671,000.00	\$ 5,343,886.00		
FY: 2006	\$ 55,335,500.00			
Total:	\$ 281,176,475.90	\$ 5,343,886.00		

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 CONTRACTS & OFFICE
 OF THE
 COMMISSIONER OF
 FINANCE AND ADMINISTRATION
 SERVICES

AMENDMENT NUMBER 10

**AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.**

CONTRACT NUMBER: FA-02-14632-10

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as follows:

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. Section 2-25 of the Agreement for the Administration of TennCare Select shall be amended by deleting and replacing the last paragraph which shall read as follows:

Payments to the Meharry Medical Services Foundation and/or the Meharry Dental Clinic under this amendment shall not exceed **\$10,000,000** for State fiscal year 2005. In addition to any interest earned, TENNCARE agrees to pay the CONTRACTOR a sum sufficient to administer this amendment in accordance with state law. The total obligation to the CONTRACTOR under this amendment including the supplemental payment to Meharry Medical Services Foundation and/or the Meharry Dental Clinic shall not exceed **\$10,204,080** for State fiscal year 2005. At such time that Federal Regulations allow, TENNCARE may discontinue making supplemental pool payments through the CONTRACTOR during State fiscal year 2005.

Amendment 10 (continued)

All of the provisions of the original Agreement not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective as of the date it is approved by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: M. D. Goetz, Jr.
M. D. Goetz, Jr.
Commissioner

DATE: 5/11/05

VOLUNTEER STATE HEALTH PLAN,
INC.

BY: Ronald E. Harr
Ronald E. Harr
President and Chief Executive Officer

DATE: April 27, 2005

APPROVED BY:

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: M. D. Goetz, Jr. IPW
M. D. Goetz, Jr.
Commissioner

DATE: MAY 13 2005

APPROVED BY:

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

BY: John G. Morgan
John G. Morgan
Comptroller

DATE: 5/18/05

CONTRACT SUMMARY SHEET

RFS Number:	318.66-026	Contract Number:	FA-02-14632-09
State Agency:	Department of Finance and Administration	Division:	Bureau of TennCare

Contractor	Contract Identification Number
VSHP (TennCare Select)	<input type="checkbox"/> V- <input type="checkbox"/> C-

Service Description

Managed Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medicaid Population

Contract Begin Date	Contract End Date
7/1/2001	12/31/2005

Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66	532	134	11	<input type="checkbox"/> STARS		
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)	
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$ 18,599,868.48	
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$ 33,079,942.80	
2004	\$ 25,125,990.72	\$ 38,364,165.90			\$ 63,490,156.62	
2005	\$ 55,335,500.00	\$ 55,335,500.00			\$ 110,671,000.00	
2006	\$ 26,667,750.00	\$ 26,667,750.00			\$ 55,335,500.00	
Total:	\$ 129,670,301.35	\$ 149,506,166.55			\$ 281,176,467.90	

CFDA#	93.778	Check the box ONLY if the answer is YES:
--------------	--------	---

State Fiscal Contract	Is the Contractor a SUBRECIPIENT? (per OMB A-133)
Name: Dean Danlel Address: 729 Church Street Phone: Nashville, TN (615)532-1362	Is the Contractor a Vendor? (per OMB A-133)
	Is the Fiscal Year Funding STRICTLY LIMITED?

Procuring Agency Budget Officer Approval Signature	Is the Contractor on STARS?
---	------------------------------------

Scott Pierce 	Is the Contractor's FORM W-9 ATTACHED?
	Is the Contractor's Form W-9 Filed with Accounts?

COMPLETE FOR ALL AMENDMENTS (only)			Funding Certification	
	Base Contract & Prior Amendments	This Amendment ONLY	Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.	
CONTRACT END DATE:	12/31/2004	12/31/2005		
FY: 2002	\$ 18,599,868.48			
FY: 2003	\$ 33,079,942.80			
FY: 2004	\$ 63,490,156.62			
FY: 2005	\$ 39,155,089.00	\$ 71,515,920.00		
FY: 2006		\$ 55,335,500.00		
Total:	\$ 154,325,095.90	\$ 126,851,420.00		

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 COMPTROLLER'S OFFICE
 OFFICE OF
 MANAGEMENT SERVICES

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 OFFICE OF
 MANAGEMENT SERVICES

AMENDMENT NUMBER 9

**AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.**

CONTRACT NUMBER: FA-02-14632-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as follows:

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. Section 6-27 shall be amended by deleting and replacing the date "December 31, 2004" with "December 31, 2005" so that the amended Section 6-27 shall read as follows:

6-27 Contract Term of The Agreement

This Agreement and its incorporated attachments, if any, as well as all Amendments to this Agreement, contain all of the terms and conditions agreed upon by the parties, and when executed by all parties, supersedes any prior agreements. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall be in effect from July 1, 2001, subject to approval by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The term of this Agreement shall expire on December 31, 2005. At the mutual agreement of TennCare and the CONTRACTOR, this CONTRACT shall be renewable for an additional twelve month period.

Notwithstanding any provision herein to the contrary, the State may terminate this Agreement if the waiver governing TennCare is terminated. The documents referenced in the Agreement are on file with the CONTRACTOR and with TENNCARE and the CONTRACTOR is aware of their content. No other agreement, oral or otherwise regarding the subject matter of this Agreement, shall be deemed to exist or to bind any of the parties hereto.

Amendment 9 (cont.)

All of the provisions of the original Agreement not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective January 1, 2005 or as of the date it is approved by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: M. D. Goetz, Jr. JG
M. D. Goetz, Jr.
Commissioner

DATE: 12/10/2004

VOLUNTEER STATE HEALTH PLAN, INC.

BY: Ronald E. Harr
Ronald E. Harr
President and Chief Executive Officer

DATE: Nov. 23, 2004

APPROVED BY:

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: M. D. Goetz, Jr. JGW
M. D. Goetz, Jr.
Commissioner

DATE: DEC 20 2004

APPROVED BY:

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

BY: John G. Morgan
John G. Morgan
Comptroller

DATE: 2/1/05

CONTRACT SUMMARY SHEET

RFS Number: 318.66-026		Contract Number: FA-02-14632-08	
State Agency: Department of Finance and Administration		Division: Bureau of TennCare	
Contractor		Contract Identification Number	
VSHP (TennCare Select)		<input type="checkbox"/> V- <input type="checkbox"/> C-	
Service Description			
Managed Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medicaid Population			
Contract Begin Date		Contract End Date	
7/1/2001		12/31/2004	
Allotment Code	Cost Center	Object Code	Fund
318.66	532	134	11
			<input type="checkbox"/> STARS
FY	State Funds	Federal Funds	Interdepartmental Funds
2002	\$ 6,755,937.23	\$ 11,843,931.25	
2003	\$ 15,785,123.40	\$ 17,294,819.40	
2004	\$ 25,125,990.72	\$ 38,364,165.90	
2005	\$ 13,935,109.85	\$ 25,219,978.15	
Total:	\$ 61,602,161.20	\$ 92,722,894.70	
CFDA#	93.778		Check the box ONLY if the answer is YES:
State Fiscal Contract			Is the Contractor a SUBRECIPIENT? (per OMB A-133)
Name:	Dean Daniel		Is the Contractor a Vendor? (per OMB A-133)
Address:	729 Church Street		Is the Fiscal Year Funding STRICTLY LIMITED?
Phone:	Nashville, TN (615)532-1362		Is the Contractor on STARS?
Procuring Agency Budget Officer Approval Signature			Is the Contractor's FORM W-9 ATTACHED?
Scott Pierce			Is the Contractor's Form W-9 Filed with Accounts?
COMPLETE FOR ALL AMENDMENTS (only)			Funding Certification
	Base Contract & Prior Amendments	This Amendment ONLY	Pursuant to T.C.A., Section 9-6-113, I. M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.
CONTRACT END DATE:			
FY: 2002	\$ 18,599,868.48		
FY: 2003	\$ 33,079,942.80		
FY: 2004	\$ 63,490,156.62		
FY: 2005	\$ 34,094,974.00	\$5,060,114.00	
FY:			
Total:	\$ 149,264,941.90	\$ 5,060,114.00	

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Office of Contracts Review

AMENDMENT NUMBER 8

**AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.**

CONTRACT NUMBER: FA-02-14632-08

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as follows:

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. Section 2-25 of the Agreement for the Administration of TennCare Select shall be amended by adding a new paragraph to the end of the existing text which shall read as follows:

Payments to the Meharry Medical Services Foundation and/or the Meharry Dental Clinic under this amendment shall not exceed \$4,958,912 for State fiscal year 2005. In addition to any interest earned, TENNCARE agrees to pay the CONTRACTOR a sum sufficient to administer this amendment in accordance with state law. The total obligation to the CONTRACTOR under this amendment including the supplemental payment to Meharry Medical Services Foundation and/or the Meharry Dental Clinic shall not exceed \$5,060,114 for State fiscal year 2005. At such time that Federal Regulations allow, TENNCARE may discontinue making supplemental pool payments through the CONTRACTOR during State fiscal year 2005.

Amendment 8 (continued)

All of the provisions of the original Agreement not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective as of the date it is approved by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

VOLUNTEER STATE HEALTH PLAN,
INC.

BY: M.D. Goetz Jr.
M. D. Goetz Jr.
Commissioner

BY: Ronald E. Harr
Ronald E. Harr
President and Chief Executive Officer

DATE: 10/25/04

DATE: Oct. 25, 2004

APPROVED BY:

APPROVED BY:

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

BY: M.D. Goetz Jr.
M. D. Goetz Jr.
Commissioner

BY: John G. Morgan
John G. Morgan
Comptroller

DATE: 10-26-04

DATE: 10-26-04

CONTRACT SUMMARY SHEET

RFS Number: 318.66-026		Contract Number: FA-02-14632-07	
State Agency: Department of Finance and Administration		Division: Bureau of TennCare	
Contractor		Contract Identification Number	
VSHP (TennCare Select)		<input type="checkbox"/> V- <input type="checkbox"/> C-	
Service Description			
Managed Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medicaid Population			
Contract Begin Date		Contract End Date	
7/1/2001		12/31/2004	
Allotment Code	Cost Center	Object Code	Fund
318.66	532	134	11
		<input type="checkbox"/> STARS	
FY	State Funds	Federal Funds	Interdepartmental Funds
2002	\$ 6,755,937.23	\$ 11,843,931.25	
2003	\$ 15,785,123.40	\$ 17,294,819.40	
2004	\$ 25,125,990.72	\$ 38,364,165.90	
2005	\$ 12,121,615.63	\$ 21,973,358.37	
Total:	\$ 59,788,666.98	\$ 89,476,274.92	
CFDA#	93.778		Check the box ONLY if the answer is YES:
State Fiscal Contract		Is the Contractor a SUBRECIPIENT? (per OMB A-133)	
Name: Dean Daniel Address: 729 Church Street Phone: Nashville, TN (615)532-1362		Is the Contractor a Vendor? (per OMB A-133)	
		Is the Fiscal Year Funding STRICTLY LIMITED?	
Procuring Agency Budget Officer Approval Signature		Is the Contractor on STARS?	
Dean Daniel <i>Dean Daniel 6/24/04</i>		Is the Contractor's FORM W-9 ATTACHED?	
		Is the Contractor's Form W-9 Filed with Accounts?	
COMPLETE FOR ALL AMENDMENTS (only)		Funding Certification	
	Base Contract & Prior Amendments	This Amendment ONLY	Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.
CONTRACT END DATE:			
FY: 2002	\$ 18,599,868.48		
FY: 2003	\$ 33,079,942.80		
FY: 2004	\$ 63,490,156.62		
FY: 2005	\$ 34,094,974.00		
FY:			
Total:	\$ 149,264,941.90	\$ -	

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 OFFICE OF
 MANAGEMENT SERVICES

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 Office of Contracts Review

AMENDMENT NUMBER 7

AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.

CONTRACT NUMBER: FA-02-14632-07

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as follows:

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. Section 1-1 shall be amended by deleting the name "Nancy Reykdal" with the name "Sonya Nelson" so that the Notice to the CONTRACTOR shall read as follows:

If to the CONTRACTOR:

Sonya Nelson
Vice President
801 Pine Street
Chattanooga, Tennessee 37402-2555

2. Section 1-3 shall be amended by deleting and replacing the definition of "Administrative Cost" so that the amended definition shall read as follows:

Administrative Cost - All costs to the Contractor related to the administration of this Agreement that are non-medical in nature, including, but not limited to:

- Satisfying Contractor Qualifications specified in Sections 2-1 and 2-2;
- Establishing and Maintaining a Provider Network in accordance with the Access and Availability requirements specified in Section 2-4.1, Attachment III and Attachment IV;
- Determination of recoveries from Third Party Liability resources in accordance with Section 2-9.8;
- Claims Processing in accordance with Section 2-9.7;
- Administration of this Agreement in accordance with Medical Management Policies and Procedures including: Utilization Management policies and procedures, including prior authorization policies and procedures established in accordance with Section 2-7.1; Referral and Exemption Requirements established in accordance with Section 2-4.4; Out of Area or Out of Plan Use policies and procedures established in accordance with Section 2-4.7; Transplant policies and procedures established in accordance with Section 2-3.12; Prescription Drug Formulary established in accordance with Section 2-3.13; Prenatal Care policies and procedures established in accordance with Section 2-7.1.f.3 and 2-3.15; Quality Monitoring/Quality Improvement Program established in accordance with Section 2-9.6; Management of Medical Care and Coordination of Care policies and procedures established in accordance with Sections 2-4.2 and 2-4.3;

Amendment 7 (cont.)

- Enrollment and Disenrollment in accordance with Section 4;
- Appeals processing and resolution in accordance with Section 2-8;
- Quality Assurance and Improvement activities as specified in Section 2-9.6 and Attachment II;
- Production and submission of required reports as specified in Section 2-10;
- Production and distribution of Marketing and Enrollee Materials as specified in Section 2-6;
- All other Administration and Management responsibilities as specified in Sections 2-11 through 2-24 and other activities required to be conducted in Attachment I, V, VI, VII, XI, XII, XIII; and
- All costs related to third party recovery or subrogation activities whether performed by the Contractor or a subcontractor.

Costs of subcontractors engaged solely to perform a non-medical administrative function for the CONTRACTOR specifically related to securing or fulfilling the CONTRACTOR's obligations to TENNCARE under the terms of this Agreement (e.g., claims processing, marketing) are considered to be an "administrative cost" with the exception of the cost of recovery of third party liability (TPL), when approved by TENNCARE.

3. Section 1-3 shall be amended by adding a new definition for "Dental Benefit Manager" which shall read as follows:

Dental Benefits Manager (DBM) - An entity responsible for the provision and administration of dental services, as defined by TENNCARE.

4. Section 1-3 shall be amended by deleting and replacing the definition of "Enrollees with Special Health Care Needs" so that the amended definition shall read as follows:

Enrollees with Special Health Care Needs – For purposes of requirements in Sections 2-4.3(l) and (m) of this Agreement, enrollees with special health care needs shall refer to enrollees identified through the Department of Children's Services (DCS).

5. Section 1-3 shall be amended by adding additional language to the definition of "Vital MCO Documents" so that the new and revised definitions shall read as follows:

Vital MCO Documents – Consent forms and notices pertaining to the reduction, denial, delay, suspension or termination of services. All vital documents must be available in Spanish.

6. Section 2-1 shall be amended by adding a new Section 2-1.u which shall read as follows:

2-1.u. The CONTRACTOR shall collect information and report to TENNCARE consistent with HEDIS requirements as defined by CMS for Medicaid. This provision does not require an independent audit by MCOs; however, TENNCARE reserves the right to audit reported information through reviews by internal and/or external staff.

7. Section 2-3.8.a shall be amended by deleting the word "pharmacy" and replacing it with the word "TennCare" so that the amended Section 2-3.8.a shall read as follows:

a. The CONTRACTOR is responsible for coordinating TennCare-covered benefits with benefits offered by other insurance, including Medicare, which the enrollee may have. For Medicaid eligibles, such coordination must insure that TennCare-covered services are delivered without charge to the enrollee except for applicable TennCare cost share responsibilities in accordance with TennCare waiver provisions and the TennCare rules and regulations.

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8. Section 2-3.11.1.f shall be amended by adding a new sentence to the end of the existing text so that the amended Section 2-3.11.1.f shall read as follows:

2-3.11.1.f The individual has voluntarily given informed consent on the approved "STERILIZATION CONSENT FORM" which is contained in this Agreement as Attachment V. The form shall be available in English and Spanish, and assistance must be provided in completing the form when an alternative form of communication is necessary.

9. Section 2-3.11.3.c shall be amended by adding a new sentence to the end of the existing text so that the amended Section 2-3.11.3.c shall read as follows:

2-3.11.3.c The individual or her authorized representative, if any, must sign and date a "STATEMENT OF RECEIPT OF INFORMATION CONCERNING HYSTERECTOMY" form, contained in this Agreement as Attachment VII, prior to the hysterectomy. Informed consent must be obtained regardless of diagnosis or age in accordance with Federal requirements. The form shall be available in English and Spanish, and assistance must be provided in completing the form when an alternative form of communication is necessary.

10. The first paragraph of Section 2-3.15 shall be amended by adding the word "TennCare" before the words "cost sharing" in the last sentence so that the amended first paragraph of Section 2-3.15 shall read as follows:

2-3.15 Prenatal Care

The CONTRACTOR shall have policies and procedures to facilitate and take reasonable steps to assist pregnant members in accessing prenatal care. This provision shall apply to enrollees in the plan who become pregnant as well as enrollees who are pregnant on the beginning date of enrollment in the plan. This provision does not intend to require all of the CONTRACTOR's network providers to accept new enrollees. However, the CONTRACTOR shall maintain a provider network consisting of providers who accept new enrollees in accordance with TennCare access standards and shall inform TENNCARE, as required, of network providers who do not accept new enrollees. In the event an enrollee entering the CONTRACTOR's plan is receiving medically necessary prenatal care services the day before enrollment, the CONTRACTOR shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided within or outside the CONTRACTOR's provider network until such time as the CONTRACTOR can reasonably transfer the enrollee to a service and/or network provider without impeding service delivery that might be harmful to the enrollee's health. The CONTRACTOR shall require, as a condition of payment, that the service provider accept the amount paid by the CONTRACTOR or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payor) plus any applicable amount of TennCare cost sharing responsibilities due from the enrollee as payment in full for the service.

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11. Section 2-3.16 shall be amended by adding new text to the end of the first paragraph, by adding new text in the second paragraph and by deleting the third paragraph so that the first two paragraphs of Section 2-3.16 shall read as follows:

2-3.16. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Requirements

The CONTRACTOR must have written policies and procedures for an EPSDT program that includes coordinating services with other TennCare providers, providing all medically necessary Title XIX EPSDT services to all eligible individuals under the age of twenty-one (21) regardless of whether the service is included in the Medicaid State Plan, as well as outreach and education. The State EPSDT program shall be referred to as "TENnderCare". The CONTRACTOR shall use "TENnderCare" in describing or naming an EPSDT program or services. This shall include, but not be limited to, all policies, procedures and/or marketing material, regardless of the format or media. No other names or labels shall be utilized. CONTRACTORS may, however, use existing EPSDT materials through December 31, 2004. Any new or reprinted EPSDT materials shall use TENnderCare as of July 1, 2004.

The CONTRACTOR shall provide EPSDT services to enrollees under age 21 in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989. EPSDT Services means early and periodic screening, diagnosis and treatment of enrollees under age 21 made pursuant to 42 U.S.C. Sections 1396a(a)(43), 1396d(a) and (r) and 42 CFR Part 441, Subpart B to ascertain children's individual (or individualized/or on an individual basis) physical and mental defects, and providing treatment to correct or ameliorate, or prevent from worsening defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered. The CONTRACTOR shall be responsible for the provision of all related services except for behavioral health services that are carved out as a separate arrangement from this Agreement as well as Pharmacy and Dental services at such time as they are removed from the responsibilities described in this Agreement. Effective upon receipt of written notification from TENNCARE, the CONTRACTOR is not required to provide services in accordance with EPSDT requirements to TennCare Standard enrollees under the age of 21.

12. Section 2-3.16.7.1.a. shall be amended by adding new text in the middle of the second sentence so that the amended Section 2-3.16.7.1.a shall read as follows:

- a. Information included in the member handbook regarding EPSDT services must be sent within thirty (30) days of receipt of notification of enrollment as specified in Section 2-6.2.c.1 and 4-1.2. Annually thereafter, upon the Enrollee's anniversary date of enrollment, the CONTRACTOR shall send an updated handbook, a supplemental update to the handbook, or a reminder of EPSDT services. All handbooks must be in accordance with the TennCare Marketing Guidelines and Section 2-6 of this Agreement.

13. Section 2-3 shall be amended by adding a new Section 2-3.19 which shall read as follows:

2-3.19 Coordination with the Department of Education

The State has implemented a program to provide federal reimbursement to local education agencies (LEAs) for medical services provided to Medicaid-eligible students in a school setting. These services must be medically necessary and included in the student's Individualized Education Plan (IEP). The purpose of this program is to assist LEAs to provide quality medical

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services to students with special needs. This program does not replace the MCOs obligation to pay for medical services for these enrollees, but allows the school districts the option to receive fee-for-service payment directly from TENNCARE where providers are direct employees of the school district or are community providers.

MCOs should continue to reimburse qualified providers for services provided in the school setting, such as services coordinated through Department of Health's Project Teach. MCOs should also continue dialogue with providers and Project Teach Coordinators to establish school-based services for students with special needs.

14. Section 2-4.3.i and j. shall be amended by adding the word "TennCare" before the words "cost sharing" so that the amended Sections 2-4.2.i and j. shall read as follows:
- i. In the event an enrollee entering the MCO's plan is receiving medically necessary TennCare covered services the day before enrollment, the CONTRACTOR shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided within or outside the CONTRACTOR's provider network until such time as the CONTRACTOR can reasonably transfer the enrollee to a service and/or network provider without impeding service delivery that might be harmful to the enrollee's health. The CONTRACTOR shall assure that the enrollee is held harmless by the provider for the costs of the service or procedure except for applicable TennCare cost sharing amounts. The CONTRACTOR shall require, as a condition of payment, that the service provider accept the amount paid by the CONTRACTOR or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payer) plus any applicable amount of TennCare cost sharing due from the enrollee as payment in full for the service. If the CONTRACTOR's payment to a non-contract provider is less than it would have been for a contract provider and the provider contests the payment amount, the CONTRACTOR shall notify the non-contract provider that the provider may initiate the independent review procedures in accordance with T.C.A. Section 56-32-226 as described in Section 2-18 of this Agreement. If it is medically necessary that care extend beyond thirty (30) days, the CONTRACTOR may require prior authorization for continuation of the services beyond thirty (30) days. Care rendered to a CONTRACTOR's enrollee beyond thirty (30) days that is out-of-plan or out-of-network for which a provider has not sought prior authorization need not be reimbursed;
 - j. In the event an enrollee entering the CONTRACTOR's plan is receiving medically necessary prenatal care services the day before enrollment, the CONTRACTOR shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided within or outside the CONTRACTOR's provider network until such time as the CONTRACTOR can reasonably transfer the enrollee to a service and/or network provider without impeding service delivery that might be harmful to the enrollee's health. The CONTRACTOR shall require, as a condition of payment, that the service provider accept the amount paid by the CONTRACTOR or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payer) plus any applicable amount of TennCare cost sharing responsibilities due from the enrollee as payment in full for the service.

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15. Section 2-4.3.1 and m. shall be amended by adding new text so that the amended Sections 2-4.3.1 and m. shall read as follows:
1. The CONTRACTOR shall implement mechanisms to assess each TennCare enrollee identified by the State as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals. Enrollees who are dually eligible for TennCare and Medicare are exempt from this requirement. For purposes of Sections 2-4.3(l) and (m), enrollees with special health care needs shall refer to enrollees identified through the Department of Children's Services (DCS), as described in Section 1-3 of this Agreement.
 - m. The CONTRACTOR shall implement procedures to share, with other MCOs, BHOs, DBMs and PBMs (as necessary) serving the enrollee, the results of its identification and assessment of any enrollee with special health care needs so that those activities need not be duplicated.
16. Sections 2-4.7.2 and 2-4.7.3 shall be amended by adding the word "TennCare" before the words "cost sharing" so that the amended Sections 2-4.7.2 and 2-4.7.3. shall read as follows:

2-4.7.2 MCO Assignment Unknown – Services Obtained from Out-of-Plan Provider

The CONTRACTOR shall include provisions governing the payment for medically necessary covered services provided to an enrollee by a non-contract or non-referred provider for services received by an enrollee any time when TENNCARE determines that the enrollee is eligible for TennCare and has enrolled the individual in the CONTRACTOR's plan and the enrollee could not have known which MCO they were enrolled in at the time of the service. The parties to this Agreement recognize that in accordance with TennCare policies and procedures, if an enrollee requests enrollment in a specified MCO, the enrollee may be assigned to an MCO other than the one that he/she requested. An example a of circumstances when an enrollee would not be enrolled in the requested MCO includes, there is not sufficient capacity in the MCO in which the enrollee requested enrollment. If an enrollee did not request enrollment in a specified MCO, the enrollee will be assigned to an MCO in accordance with TennCare policies and procedures. In either case, the effective date of enrollment may occur prior to the MCO being notified of the enrollee becoming a member of the plan. When this situation arises, the MCO shall not deny medically necessary services provided during this period of eligibility for lack of prior authorization or lack of referral; likewise, an MCO shall not deny a claim on the basis of the provider's failure to file a claim within a specified time period after the date of service when the provider could not have reasonably known which MCO the enrollee was in during the timely filing period. However, in such cases the MCO may impose timely filing requirements beginning on the date of notification of the individual's enrollment. When an enrollee has incurred medically necessary medical expenses that are covered benefits during a period of enrollment in the plan, the CONTRACTOR shall make reimbursement for the medical services and shall assure that the enrollee is held harmless by the provider for the costs of the service or procedure except for applicable TennCare cost sharing amounts. The CONTRACTOR shall require, as a condition of payment, that the service provider accept the amount paid by the CONTRACTOR or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payor) plus any applicable amount of TennCare cost sharing responsibilities due from the enrollee as payment in full for the service. Failure to provide coverage of a service or make payments for a service within five (5) calendar days of a directive from TENNCARE shall result in the application of liquidated damages as described in Section 6-8 of this Agreement.

2-4.7.3 Medically Necessary Services obtained from Out of Plan Providers/Referred by Contract Provider

The CONTRACTOR shall include provisions governing the referral and payment for medically necessary services provided to an enrollee by a non-contract provider at the request of a contract provider. The CONTRACTOR's payment shall not be less than eighty percent (80%) of the rate that would have been paid by the plan if the enrollee had received the services from a provider who is participating in the CONTRACTOR's plan. The CONTRACTOR shall require the out-of-plan provider to accept the CONTRACTOR's payment, plus applicable TennCare cost sharing responsibilities as payment in full for the service(s) as required by TennCare rules and regulations and Section 2-3.1 of this Agreement.

17. Section 2-4.11 shall be deleted and replaced in its entirety so that the amended Section 2-3.i shall read as follows:

2-4.11 Cost-Sharing

The CONTRACTOR and all providers and subcontractors shall not require any cost sharing responsibilities for TennCare covered services except to the extent that cost sharing responsibilities are required for those services by TENNCARE in accordance with TennCare rules and regulations, including but not limited to, holding enrollees liable for debt due to insolvency of the MCO or non-payment by the State to the MCO. Further, the CONTRACTOR and all providers and subcontractors may not charge enrollees for missed appointments.

TennCare cost sharing responsibilities shall apply to services other than the preventive services described in Section 2-3.3 of this Agreement. Copayments shall be applied on a sliding scale according to the enrollee's income. The maximum out-of-pocket expenses an enrollee may incur as the result of cost sharing responsibilities shall also be limited according to the enrollee's income. The current sliding scale schedule to be used in determining applicable cost sharing responsibilities and out-of-pocket expenses is included in this Agreement as Attachment XI. The CONTRACTOR shall track and report to TENNCARE the amount of enrollee cost-sharing liabilities on a quarterly basis in a form and format to be specified by TENNCARE. TENNCARE shall aggregate cost-sharing information submitted by TennCare MCOs, BHOs and the PBM to identify enrollees that have met or exceeded their annual out-of-pocket expenditure maximum. The CONTRACTOR agrees to coordinate reimbursement to enrollees, either directly or through its network providers, that have exceeded the applicable out-of-pocket maximum, upon receipt of notification by TENNCARE. Should the CONTRACTOR elect to reimburse enrollees through its network providers, the CONTRACTOR shall conduct an audit of the providers that have been reimbursed in order to assure that enrollees received appropriate credit and/or reimbursement and are held harmless for amounts that exceed their out-of-pocket maximum.

The CONTRACTOR shall be expressly prohibited from waiving or using any alternative TennCare cost sharing schedules, unless required by TENNCARE.

If, and at such time that TENNCARE amends any TennCare rules or regulations, including but not limited to the TennCare cost sharing rules, the rules shall automatically be incorporated into this Agreement and become binding on the CONTRACTOR and its providers.

Providers or collection agencies acting on the provider's behalf may not bill enrollees for amounts other than applicable TennCare cost sharing responsibilities for TennCare covered services except as permitted by

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TennCare rule 1200-13-12-.08, 1200-13-13-.08, 1200-13-14-.08 and as described below. Providers may seek payment from an enrollee in the following situations:

1. if the services are not covered by TennCare and the provider informed the enrollee the services were not covered prior to providing the service. The provider is required to inform the enrollee of the non-covered service and have the enrollee acknowledge the information. If the enrollee still requests the service, the provider shall obtain such acknowledgment in writing prior to rendering the service. Regardless of any understanding worked out between the provider and the enrollee about private payment, once the provider bills an MCO for the service that has been provided, the prior arrangement with the enrollee becomes null and void without regard to any prior arrangement worked out with the enrollee; or
2. if the enrollee's TennCare eligibility is pending at the time services are provided and if the provider informs the person they will not accept TennCare assignment whether or not eligibility is established retroactively. Regardless of any understanding worked out between the provider and the enrollee about private payment, once the provider bills an MCO for the service the prior arrangement with the enrollee becomes null and void without regard to any prior arrangement worked out with the enrollee; or
3. if the enrollee's TennCare eligibility is pending at the time services are provided, however, all monies collected, except applicable TennCare cost share amounts must be refunded when a claim is submitted to an MCO if the provider agreed to accept TennCare assignment once retroactive TennCare eligibility was established. (The monies collected shall be refunded as soon as a claim is submitted and shall not be held conditionally upon payment of the claim); or
4. the enrollee requests services that are non-TennCare covered services provided at the option of the CONTRACTOR in accordance with the terms of this Agreement.

The CONTRACTOR shall require, as a condition of payment, that the service provider accept the amount paid by the CONTRACTOR or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payor) plus any applicable amount of TennCare cost sharing responsibilities due from the enrollee as payment in full for the service. Should a provider, or a collection agency acting on the provider's behalf, bill an enrollee for amounts other than the applicable amount of TennCare cost sharing responsibilities due from the enrollee, once a CONTRACTOR becomes aware the CONTRACTOR shall notify the provider and demand that the provider and/or collection agency cease such action against the enrollee immediately. After notification by the CONTRACTOR, if a provider continues to bill an enrollee, the CONTRACTOR shall refer the provider to the TBI.

18. The first paragraph in Section 2-6.2.c.1 shall be deleted and replaced in its entirety so that the new first paragraph in Section 2-6.2.c.1 shall read as follows:

1. Member Handbooks. The CONTRACTOR shall update or develop their member handbook annually unless otherwise specified by TENNCARE. As described by TENNCARE, the annual requirement to update and or develop member handbooks may be delayed or modified as the result of major modifications and/or reform efforts being implemented in the TennCare program. Member handbooks must be approved by TennCare prior to distribution. Member handbooks must be distributed to enrollees within thirty (30) days of receipt of notice of enrollment in the CONTRACTOR's plan. In situations where there is more than one enrollee in a TennCare case, it shall be acceptable for the CONTRACTOR to mail one (1) member handbook to each address listed for the enrollee's TennCare case number when there is more than one (1) new enrollee

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assigned to the same case number at the time of enrollment and when subsequent new or updated member handbooks are mailed to enrollees. Should a single individual be enrolled and be added into an existing case, a member handbook new or updated must be mailed to that individual regardless of whether or not a member handbook has been previously mailed to enrollees in the existing case. Upon notice by TENNCARE of material changes, the CONTRACTOR shall make the appropriate revisions to maintain and redistribute the member handbooks immediately. The CONTRACTOR shall as appropriate, maintain and provide two (2) separate versions of the CONTRACTOR's TennCare Member Handbook for the specific population being served for the purpose of describing Medicaid Benefits to the Medicaid population and Standard Benefits to the Standard population. All revisions must be approved by TENNCARE prior to dissemination. Each member handbook shall, at a minimum, be in accordance with the following guidelines:

19. Section 2-6.2.c.1.e shall be amended by adding the word "TennCare" before the words "cost sharing.

20. Section 2-6.2.c.1 shall be amended by adding a new Section 2-6.2.c.1.j and renumbering the existing subsections (j) through (v) accordingly. The new Sections 2-6.2.c.1.j shall read as follows:

2-6.2.c.1.j Shall include notice to the enrollee of the right to file a complaint as is provided for by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1975, the Age Discrimination Act of 1975, the Omnibus Budget Reconciliation Act of 1981 (P.E.. 97-35) and a complaint form on which to do so.

21. Sections 2-6.2.c.2, 2-6.2.c.3 and 2-6.2.c.4 shall be deleted and replaced in their entirety so that the amended Sections 2-6.2.c.2, 2-6.2.c.3 and 2-6.2.c.4 shall read as follows:

2-6.2.c. 2. Quarterly Newsletter. The CONTRACTOR shall, at a minimum, distribute on a quarterly basis a newsletter to all enrollees which is intended to educate the enrollee to the managed care system, proper utilization of services, etc., and encourage utilization of preventive care services. The CONTRACTOR shall include the following information in each newsletter:

- a. specific articles or other specific information as described when requested by TENNCARE. Such requests by TENNCARE shall be limited to two hundred (200) words and shall be reasonable including sufficient notification of information to be included; and
- b. the procedure on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free;
- c. a notice to enrollees of the right to file a complaint, as is provided for by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1975, the Age Discrimination Act of 1975, the Omnibus Budget Reconciliation Act of 1981 (P.E.. 97-35), and a Contractor phone number for doing so. The notice shall be English and Spanish; and
- d. For TennCare Medicaid enrollees, EPSDT information, including but not limited to, encouragement to obtain screenings and other preventive care services.

Not more than one hundred twenty (120) calendar days shall elapse between dissemination of this information. In order to satisfy the requirement to distribute the quarterly newsletter to all enrollees, it shall be acceptable to mail one (1) quarterly newsletter to each address associated with the enrollees TennCare case number. In addition to the prior authorization requirement regarding dissemination of materials to enrollees, the CONTRACTOR shall also submit to TENNCARE, five (5) final printed originals, unless otherwise specified by TENNCARE, of the newsletter and the date that the information was mailed to enrollees along with an invoice or other type of documentation to indicate the date and volume of the quarterly newsletter mailing.

2-6.2.c.3. Identification Cards. The CONTRACTOR shall provide enrollees with identification cards. The cost of these items shall be borne by the CONTRACTOR. The State shall review and approve identification cards prior to issuance for use. Each enrollee shall be provided an identification card, which identifies the enrollee as a participant in the TennCare Program within thirty (30) calendar days of notification of enrollment into the CONTRACTOR's plan. The identification card must comply with all state and federal requirements, including but not limited to, the Standardized Pharmacy Benefit Identification Card Act. Once the identification card has been approved by TENNCARE the CONTRACTOR shall submit five (5) printed sample cards of the final product, unless otherwise specified by TENNCARE, to the TennCare Marketing Coordinator within thirty (30) working days from the print date. Photo copies may not be submitted as a final product. Prior to modifying an approved identification card the CONTRACTOR shall submit for approval by TENNCARE a detailed description of the proposed modification. The identification card may be issued by the CONTRACTOR, subject to prior approval of the format and content by TENNCARE.

2-6.2.c. 4. The CONTRACTOR shall be responsible for distributing provider directories to new members within thirty (30) calendar days of receipt of notification of enrollment in the plan. The CONTRACTOR shall also be responsible for redistribution of updated provider information on a regular basis and shall redistribute a complete and updated provider directory at least on an annual basis. Provider directories shall include the following: names, locations, telephone numbers, office hours, non-English languages spoken by current network PCPs and specialists, hospital listings including locations of emergency settings and post stabilization services, identification of providers accepting new patients and whether or not a provider performs EPSDT screens. Enrollee provider directories, and any revisions thereto, shall be submitted to TENNCARE for approval prior to distribution to enrollees. Each submission shall include a paper and an electronic copy. The text of the directory shall be in Microsoft Word or Adobe (PDF) format. In addition, the provider information used to populate the enrollee provider directory shall be submitted as a TXT file or such format as otherwise approved by TENNCARE and be produced using the same extract process as the actual enrollee provider directory. In situations where there is more than one enrollee in a TennCare case, it shall be acceptable for the CONTRACTOR to mail one (1) provider directory to each address listed for the enrollee's TennCare case number when there is more than one (1) new enrollee assigned to the same case number at the time of enrollment and when subsequent updated provider directories are mailed to enrollees. Should a single individual be enrolled and be added into an existing case, a provider directory must be mailed to that individual regardless of whether or not a provider directory has been previously mailed to enrollees in the existing case. These updates shall be maintained in accordance with Section 2-1.0 of this Agreement.

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22. Section 2-6.5 shall be deleted in its entirety and replaced by a new Section 2-6.5 which shall read as follows:

2-6.5 Prior Approval

- a. If the CONTRACTOR chooses to prepare a marketing plan, the CONTRACTOR shall submit a detailed description of its^u marketing plan for approval. If the CONTRACTOR chooses to use marketing material previously approved for a prior event, the CONTRACTOR shall submit samples of these materials for review and approval with their submission. Further, The CONTRACTOR shall submit any materials it intends to use and a description of any marketing activities to be held prior to implementation or use. This includes but is not limited to all policies and manuals, advertisement copy, brochures, posters, fact sheets, video tapes, story boards for the production of videos, audio tapes, newsletters, any and all other forms of advertising as well as any other forms of public contact such as participation in health fairs and/or telemarketing scripts.
 - b. All materials submitted by the CONTRACTOR shall be accompanied by a plan that describes the CONTRACTOR's intent and procedure for the use of the materials. All written material submitted by the CONTRACTOR must be submitted on paper and electronic file media. Materials developed by a recognized entity having no association with the CONTRACTOR that are related to management of specific types of diseases (e.g., heart, diabetes, asthma, etc.) or general health improvement must be submitted for approval; however, an electronic file for these materials may not be required. The electronic files, when required, must be submitted in a format acceptable to TENNCARE. Electronic files submitted in any other format than those approved by TENNCARE cannot be processed.
 - c. TENNCARE shall review the Contractor's marketing plan, marketing activity descriptions and materials and either approve, deny or return the plan and/or materials (with written comments) within fifteen (15) calendar days from the date of submission.
 - d. Once materials have been approved by TENNCARE, the CONTRACTOR shall submit an electronic version of the final printed product and five (5) original prints of the final product, unless otherwise specified by TENNCARE, to the TennCare Marketing Coordinator within thirty (30) working days from the print date. Photo copies may not be submitted as a final product. Upon request, the CONTRACTOR shall provide additional original prints of the final product to TENNCARE.
 - e. Marketing problems may not be evident from the materials submitted, but may become apparent upon use. TennCare reserves the right to notify the CONTRACTOR to discontinue or modify marketing plans, activities or materials after approval.
 - f. Prior to modifying any approved marketing plan, marketing activity or material, the CONTRACTOR shall submit for approval by TennCare a detailed description of the proposed modification.
23. Section 2-6.6.6 shall be amended by adding a new sentence in the middle of the existing text so that the amended Section 2-6.6.6 shall read as follows:

2-6.6.6. The CONTRACTOR shall develop a written procedure for the provision of language interpretation and translation services for any enrollee who needs such services, including but not limited to, enrollees with Limited English Proficiency. The CONTRACTOR shall provide for

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these enrollees, language help-lines with specific numbers. The CONTRACTOR shall provide instruction for its staff and all direct service sub-contractors regarding the procedure.

24. Section 2-7.1.f.3 shall be amended by adding the word "TennCare" before the words "cost sharing" in the last sentence.
25. The last sentence in Section 2-8.1.10 shall be amended by deleting the incorrect reference to "Section 4-8.b.2" and replacing it with the reference "Section 6-8.2.2".
26. Section 2-9.2.6 shall be deleted in its entirety and replaced by a new Section 2-9.2.6 which shall read as follows:
 6. The CONTRACTOR shall appoint a staff person as its Non-discrimination Compliance Coordinator to be responsible for compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1975, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981 (P.E.. 97-35) on behalf of the CONTRACTOR. The CONTRACTOR does not have to require that compliance with the aforementioned federal and state regulations be the sole function of the designated staff member. However, the CONTRACTOR shall identify the designated compliance staff member to TENNCARE by name. At such time that this function is redirected, the name of the staff member who assumed the duties shall be reported in writing to TENNCARE within ten (10) calendar days of the change;
27. Section 2-9.2.9 shall be amended by deleting the term "Title VI" and replacing it with the term "Non-discrimination Compliance".
28. Section 2-9.7 shall be amended by adding a new item l which shall read as follows:
 1. Timely Filing. Consistent with the requirements outlined in Section 2-18.jj of this Agreement, the CONTRACTOR shall not deny provider claims on the basis of timely filing in situations regarding coordination of benefits or subrogation in which case the provider is pursuing payment from a third party or if an enrollee is enrolled in the plan with a retroactive eligibility date. In situations of third party benefits, the minimum and maximum time frames for filing a claim shall begin on the date that the third party documented resolution of the claim. In situations of enrollment in the plan with a retroactive eligibility date, the minimum and maximum time frames for filing a claim shall begin on the date that the CONTRACTOR receives notification from TENNCARE of the enrollee's eligibility.
29. Section 2-9.8.b and 2-9.8.c shall be amended by adding new text to the end of the existing text and Section 2-9.8.e shall be amended by adding the word "TennCare" to the beginning of the sentence so that the amended Sections 2-9.8.b, 2-9.8.c and 2-9.8.e shall read as follows:
 - 2-9.8.b If the CONTRACTOR has determined that third party liability exists for part or all of the services provided to an enrollee by a provider, the CONTRACTOR shall pay the provider only the amount, if any, by which the provider's allowable claim exceeds the amount of third party liability. The CONTRACTOR and all providers and subcontractors shall not require any cost sharing responsibilities for TennCare covered services except to the extent that cost sharing responsibilities are required for those services by TENNCARE.
 - 2-9.8.c The CONTRACTOR may not withhold payment for services provided to a member if third party liability or the amount of liability cannot be determined, or payment will not

Amendment 7 (cont.)

be available within a reasonable time. Except for the claims described below, if the probable existence of third party liability has been established at the time the claim is filed, the CONTRACTOR must reject the claim and return it to the provider for a determination of the amount of any third party payment. When the amount of payment is determined, the CONTRACTOR shall pay the claim at the rate allowed under the CONTRACTOR's payment schedule. In no instance shall the amount of the third party payment and the CONTRACTOR's payment exceed the provider's contracted TennCare rate. The claims exceptions are EPSDT, prenatal or preventive pediatric care, and all claims covered by absent parent maintained insurance under Part D of Title IV of the Social Security Act.

2-9.8.e. TennCare Cost sharing responsibilities permitted pursuant to Section 2-4.10 of this Agreement shall not be considered third party resources for purposes of this requirement.

30. Section 2-10.9.1 shall be amended by deleting the term "Title VI" and replacing it with the term "Non-discrimination Compliance" in both the title and the text of the Section.

31. Section 2-10. shall be amended by adding a new Section 2-10.16 which shall read as follows:

2-10.16. Prior Authorization Reporting

On a monthly basis, the CONTRACTOR shall provide a summary of all requests for prior authorization by type of service (e.g., Inpatient, Home Health, Therapy, Durable Medical Equipment, etc.) received in the preceding month that will include, at a minimum, the following information:

- Total number of requests for prior authorization received;
- Total number of requests for prior authorization processed;
- Total number of requests approved; and
- Total number of requests denied, sub categorized by denial reason [e.g., 10 total denied, 5 – denied for member not eligible, 3 – denied....., etc.(list very specific denial reasons)].

This information shall be reported on an Excel file in the format acceptable to TENNCARE and shall be sent to TENNCARE electronically. Failure to provide monthly reports of authorization activities, as specified above, shall result in the application of liquidated damages as described in Section 6-8 of this Agreement.

32. Sections 2-18.f and 2-18.x shall be amended by adding the word "TennCare" before the words "cost sharing".

33. Section 2-18.jj shall be deleted and replaced in its entirety so that the amended Section 2-18.jj shall read as follows:

2-18. jj. Specify that a provider shall have at least, but no more than one hundred and twenty (120) calendar days from the date of rendering a health care service to file a claim with the CONTRACTOR except in situations regarding coordination of benefits or subrogation in which case the provider is pursuing payment from a third party or if an enrollee is enrolled in the plan with a retroactive eligibility date. In situations of third party benefits, the maximum time frames for filing a claim shall begin on the date that the third party documented resolution of the claim. In situations of enrollment in the plan with a

Amendment 7 (cont.)

retroactive eligibility date, the minimum and maximum time frames for filing a claim shall begin on the date that the CONTRACTOR receives notification from TENNCARE of the enrollee's eligibility;

34. Section 2-18 shall be amended by adding a new item tt which shall read as follows:

2-18.tt. Require the provider to comply and submit to the CONTRACTOR disclosure of information in accordance with the requirements specified in 42 CFR, Part 455, Subpart B.

35. Section 2-24 shall be deleted in its entirety and replaced by a new Section 2-24 which shall read as follows:

2-24. Non-Discrimination Compliance

No person on the grounds of handicap, and/or disability, age, race, color, religion, sex, or national origin, shall be excluded from participation in, except as specified in Section 2 of this Agreement, or be denied benefits of, or be otherwise subjected to discrimination in the performance of this Agreement or in the employment practices of the CONTRACTOR. The CONTRACTOR shall upon request show proof of such non-discrimination, and shall post in conspicuous places, available to all employees and applicants, notices of non-discrimination.

In order to demonstrate compliance with Federal and State regulations of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1975, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981 (P.E. 97-35) the CONTRACTOR shall:

2-24.a. Designate a staff person to be responsible for Title VI compliance on behalf of the CONTRACTOR. The designated staff person shall be identified by name in writing to TENNCARE within thirty (30) days of the effective date of this Agreement. The CONTRACTOR does not have to require that Title VI compliance be the sole function of the designated staff person.

2-24.a.1. In respect to any period of time that the CONTRACTOR does not have a designated staff person responsible for non-discrimination compliance it shall be reported to TENNCARE in writing, to the attention of the Director of Non-discrimination Compliance/Health Care Disparities, within ten (10) calendar days of the commencement of such period of time. At such time that this function is redirected, the name of the staff member who assumed the duties shall be reported to TENNCARE, to the attention of the Director of Non-discrimination Compliance/Health Care Disparities, within ten (10) calendar days of the change.

2-24.b. The CONTRACTOR shall develop written policy and procedures for the provision of language interpretation and translation services for any enrollee who needs such services, including but not limited to, enrollees with Limited English Proficiency. The CONTRACTOR's Non-discrimination Compliance Coordinator shall provide instruction for its staff, including but not limited to, all providers and direct service sub-contractors regarding the procedure.

Amendment 7 (cont.)

- 2-24.c. On an annual basis, the CONTRACTOR shall submit a copy of the CONTRACTOR's personnel policies that, at a minimum; emphasize non-discrimination in hiring, promotional, operational policies, contracting processes and participation on advisory/planning boards or committees.
- 2-24.d. On a quarterly basis, the CONTRACTOR shall submit a summary listing totaling the number of supervisory personnel by race/national origin and sex. The CONTRACTOR is required to request this information from all CONTRACTOR staff. CONTRACTOR staff response is voluntary. The CONTRACTOR is prohibited from utilizing information obtained pursuant to such a request as a basis for decisions regarding employment or in determination of compensation amounts. Such listing shall separate categories for total supervisory personnel by; number of male supervisors who are White, Black (not of Hispanic origin), American Indian or Alaskan Native, Asian or Pacific Islander, Hispanic origin and other race/national origin as indicated by staff and number of female supervisors who are White, Black (not of Hispanic origin), American Indian or Alaskan Native, Asian or Pacific Islander, Hispanic origin and other race/national origin females as indicated by staff.
- 2-24.e. On an annual basis, the CONTRACTOR shall submit a summary listing by CSA of servicing providers which includes race or ethnic origin of each provider. The listing shall include, at a minimum, provider name, address, race/ethnic origin (to be indicated as in Section 2-24.d) and shall be sorted by CSA. Each provider type (e.g., physician, dentist, etc.) shall be reported separately within the CSA. Primary care providers shall be reported separately from other physician specialties. The CONTRACTOR is required to request this information from all providers. Provider response is voluntary. The CONTRACTOR is prohibited from utilizing information obtained pursuant to such a request as a basis for decision regarding participation in the CONTRACTOR's provider network or in determination of compensation amounts.
- 2-24.f. On a quarterly basis, the CONTRACTOR shall submit a listing of all complaints alleging discrimination filed by employees (when the complaint is related to TennCare benefits provided by the CONTRACTOR), enrollees, providers and subcontractors in which discrimination is alleged in the CONTRACTOR's TennCare Plan. Such listing shall include, at a minimum, the identity of the party filing the complaint, the complainant's relationship to the CONTRACTOR, the circumstances of the complaint, date complaint filed, CONTRACTOR's resolution, if resolved, and name of CONTRACTOR staff person responsible for adjudication of the complaint.
- 2-24.g. On a quarterly basis, a listing of all requests for translation/interpretation services by requesting enrollee.
- 2-24.g.1. Each request reported will identify by name and member identification number the enrollee for which translation/interpretation service was provided, the date of the request, the date provided, and the identification of the translator/interpreter.
- 2-24.h. On an annual basis, a copy of the CONTRACTOR's policy, that demonstrates non-discrimination in provision of services to persons with Limited English Proficiency.
- 2-24.h.1. A listing of the interpreter/translator services utilized by the CONTRACTOR in providing services to enrollees with Limited English Proficiency. The listing shall provide the full name of interpreter/translator services, address of services, phone number of services, hours services are available and be sorted by CSA.
- 2-24.i. On an annual basis, the CONTRACTOR's Title VI Compliance Plan and Assurance of Non-discrimination.

Amendment 7 (cont.)

36. Section 4-1.1.k shall be amended by adding new text so that the amended Section 4-1.1.k shall read as follows:

k. Enrollment shall begin at 12:01 a.m. on the effective date that the enrollee is enrolled in the CONTRACTOR's plan and shall end at 12:00 midnight on the date that the enrollee is disenrolled pursuant to the criteria in TennCare policy and/or TennCare rules and regulations. Children and Women who are determined presumptively and/or immediately eligible are given immediate TennCare eligibility and a temporary identification form to confirm eligibility pending the issuance of a regular identification card by their selected MCO. The purpose of this temporary identification/eligibility confirmation form is to enable the women to access prenatal care at the earliest possible time and to ensure all children in DCS custody are provided with medical services, including EPSDT screenings. In accordance with TennCare rules, policies and procedures, the effective date of enrollment may occur prior to the MCO being notified of the enrollee becoming a member of the plan. The CONTRACTOR shall be responsible for arranging for the provision of services and payment of all covered services during the period of enrollment.

37. Section 4-2.1 shall be amended by adding a new item c. and renumbering the existing c. as d. so that the new Section 4-2.1.c shall read as follows:

At such time that individuals may be enrolled in the Program of All-inclusive Care for the Elderly (PACE), they shall no longer remain eligible to be enrolled in an MCO.

38. Section 6-1 shall be amended by adding a new Section 6-1.dd which shall read as follows:

6-1. dd. TennCare Reform Legislation signed May 11, 2004 and any subsequent implementation schedule as specified by TENNCARE.

39. Item E in the paragraph regarding Performance Guarantees of Section 6-28 shall be deleted and replaced in its entirety so that the amended Item E shall read as follows:

<p>E. Encounter Data Submissions</p>	<p>TennCare Edit Reports</p>	<p>Error Threshold Exceeded</p>	<p>Less than 2% of file contains errors by submission due date</p>	<p>A maximum of \$10,000 per month, or a per submission fine of \$2500 for each failed submission. In the event TENNCARE provides less than ninety (90) calendar days advance notice prior to changing edits penalties shall not be applied.</p>
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Amendment 7 (cont.)

40. Section II of Attachment I shall be amended by adding a new Item EE and renumbering the remaining Items appropriately, including any references thereto so that the new Item EE shall read as follows:

EE	Prior Authorization Summary in accordance with Section 2-10.16	Monthly, by the 20 th of the following month to TENNCARE
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41. Renumbered Items II through OO of Section II of Attachment I shall be deleted and replaced in their entirety so that the amended Items II through OO shall read as follows:

II	Annual submission of personnel/ operational policies that emphasize non-discrimination in hiring, promotional and contracting processes as described in Section 2-24	Annually, within ninety (90) calendar days after the end of the year to the Director of Non-discrimination Compliance/ Health Care Disparities
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JJ	Quarterly listing of complaints filed alleging discrimination as described in Section 2-24	Quarterly, by the 30 th of the following month to the Director of Non-discrimination Compliance/Health Care Disparities
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KK	Quarterly listing of supervisory personnel as described in Section 2-24	Quarterly, by the 30 th of the following month to the Director of Non-discrimination Compliance/Health Care Disparities
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LL	Annual listing by CSA of non-institutional providers as described in Section 2-24	Annually, within ninety (90) calendar days after the end of the year to the Director of Non-discrimination Compliance/Health Care Disparities
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MM	Annual copy of CONTRACTOR's policy regarding non-discrimination of services to persons with Limited English Proficiency as described in Section 2-24	Annually, within ninety (90) calendar days after the end of the year to the Director of Non-discrimination Compliance/Health Care Disparities
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NN	On a Quarterly basis, a listing of all request of translation or interpreter services as described in Section 2-24.g.1.	Quarterly, by the 30 th of the following month to the Director of Non-discrimination Compliance/Health Care Disparities
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OO	Annual Compliance Plan as described in Section 2-24	On an annual basis to the Director of Non-discrimination Compliance/Health Care Disparities
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42. Part D of Standard X of Attachment II shall be amended by adding new Items 11 and 12 which shall read as follows:

- 11. procedures for filing a discrimination complaint; and
- 12. procedures for obtaining communication/language assistance.

Amendment 7 (cont.)

43. Item 2 of Part A of Standard XII of Attachment II shall be amended by adding new text so that the amended Attachment II, A.2 shall read as follows:

2. availability of emergency equipment and procedures;

44. Part 4 of Attachment XI shall be deleted in its entirety and replaced by a new part 4 which shall read as follows:

(a) Effective January 1, 2003, copayment amounts for TennCare Standard enrollees shall be:

Poverty Level	Copayment Amounts
0%-99%	\$0.00
100% - 199%	\$25.00, Hospital Emergency Room (waived if admitted) \$5.00, Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care \$15.00, Physician Specialists (including Psychiatrists) \$5.00, Prescription or Refill \$100.00, Inpatient Hospital Admission
200% and above	\$50.00, Hospital Emergency Room (waived if admitted) \$10.00, Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care \$25.00, Physician Specialists (including Psychiatrists) \$10.00, Prescription or Refill \$200.00, Inpatient Hospital Admission

Amendment 7 (cont.)

All of the provisions of the original Agreement not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective July 1, 2004 or as of the date it is approved by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: M. D. Goetz, Jr.
M. D. Goetz, Jr.
Commissioner

DATE: 6/25/04

VOLUNTEER STATE HEALTH PLAN, INC.

BY: Ronald E. Harr
Ronald E. Harr
President and Chief Executive Officer

DATE: June 23, 2004

APPROVED BY:

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: M. D. Goetz, Jr.
M. D. Goetz, Jr.
Commissioner

DATE: JUN 26 2004

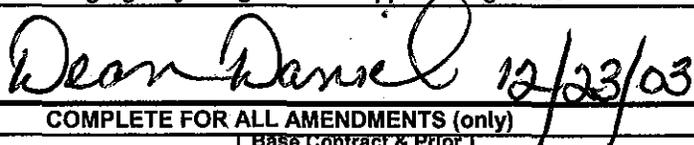
APPROVED BY:

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

BY: John G. Morgan
John G. Morgan
Comptroller

DATE: 7/2/04

CONTRACT SUMMARY SHEET

RFS Number: 318.66-026		Contract Number: FA-02-14632-06	
State Agency: Department of Finance and Administration		Division: Bureau of TennCare	
Contractor		Contract Identification Number	
VSHP (TennCare Select)		<input type="checkbox"/> V- <input type="checkbox"/> C-	
Service Description			
Managed Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medicaid Population			
Contract Begin Date		Contract End Date	
7/1/2001		12/31/2004	
Allotment Code	Cost Center	Object Code	Fund
318.66	839	134	11
		<input type="checkbox"/> STARS	
FY	State Funds	Federal Funds	Interdepartmental Funds
2002	\$ 6,755,937.23	\$ 11,843,931.25	
2003	\$ 15,785,123.40	\$ 17,294,819.40	
2004	\$ 25,125,990.72	\$ 38,364,165.90	
2005	\$ 12,121,615.63	\$ 21,973,358.37	
Total:	\$ 59,788,666.98	\$ 89,476,274.92	
CFDA#	93.778		Check the box ONLY if the answer is YES:
State Fiscal Contract			Is the Contractor a SUBRECIPIENT? (per OMB A-133)
Name: Dean Daniel Address: 729 Church Street Nashville, TN Phone: (615)532-1362			Is the Contractor a Vendor? (per OMB A-133)
			Is the Fiscal Year Funding STRICTLY LIMITED?
Procuring Agency Budget Officer Approval Signature			Is the Contractor on STARS?
Dean Daniel 			Is the Contractor's FORM W-9 ATTACHED?
			Is the Contractor's Form W-9 Filed with Accounts?
COMPLETE FOR ALL AMENDMENTS (only)			Funding Certification
		Base Contract & Prior Amendments	This Amendment ONLY
CONTRACT END DATE:			
FY: 2002		\$ 18,599,868.48	
FY: 2003		\$ 33,079,942.80	
FY: 2004		\$ 29,395,182.62	\$ 34,094,974.00
FY: 2005			\$ 34,094,974.00
FY:			
Total:		\$ 81,074,993.90	\$ 68,189,948.00

Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.

RECEIVED
 2004 JAN - 8 AM 11: 40
 COMPTROLLER'S OFFICE
 DEPARTMENT OF
 REVENUE
 MANAGER SERVICES

AMENDMENT NUMBER 6

AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.

CONTRACT NUMBER: FA-02-14632-06

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as follows:

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. Section 1-3 shall be amended by amending the definitions of "Emergency Medical Services" and "Post-stabilization Care Services" by adding new phrases in each of the existing definitions so that the amended definition for "Emergency Medical Services" and "Post-stabilization Care Services" shall read as follows:

Emergency Medical Services (or Emergency Services) – Covered inpatient and outpatient services furnished by a qualified provider that are needed to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard, including services for which the absence of immediate medical attention would not have had the outcomes specified in the definition of emergency medical condition; and emergency ambulance transport.

Post-stabilization Care Services - Non-emergency services subsequent to an emergency that a treating physician views as medically necessary to maintain the stabilized condition after an emergency medical condition has been stabilized or to improve or resolve the enrollee's condition. An MCOs financial responsibility for post stabilization care services shall end when one of the following are met:

1. A plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care;
2. A plan physician assumes responsibility for the enrollee's care through transfer;
3. An MCO representative and the treating physician reach an agreement concerning the enrollee's care; or
4. The enrollee is discharged.

2. The "Physician Outpatient Services/Community Health Clinic Services/Other Clinic Services" benefit in Section 2-3.1.1 shall be amended by adding additional language so that the amended "Physician Outpatient Services/Community Health Clinic Services/Other Clinic Services" of Section 2-3.1.1 shall read as follows:

Physician Outpatient Services/Community Health Clinic Services/Other Clinic Services	As medically necessary. This shall include acupuncture performed by a Physician or a registered nurse as an anesthetic in connection with a surgical procedure and services provided by a Primary Care Provider with a primary behavioral health diagnosis (ICD-9-CM 290.xx - 319.xx). CONTRACTOR covered services shall also include medical evaluations provided by a neurologist, as approved by the CONTRACTOR, and/or an emergency room physician, that result in a primary behavioral health diagnosis (ICD-9-CM 290.xx - 319.xx).
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Amendment 6 (continued)

3. The “**Physician Outpatient Services/Community Health Clinic Services/Other Clinic Services**” benefit in Sections 2-3.1.2 and 2-3.1.3 shall be amended by adding additional language so that the amended “**Physician Outpatient Services/Community Health Clinic Services/Other Clinic Services**” of Sections 2-3.1.2 and 2-3.1.3 shall read as follows:

Physician Outpatient Services/Community Health Clinic Services/Other Clinic Services	As medically necessary. This shall include services provided by a Primary Care Provider with a primary behavioral health diagnosis (ICD-9-CM 290.xx - 319.xx). CONTRACTOR covered services shall also include medical evaluations provided by a neurologist, as approved by the CONTRACTOR, and/or an emergency room physician, that result in a primary behavioral health diagnosis (ICD-9-CM 290.xx - 319.xx).
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4. Section 2-3.5 shall be deleted amended by adding additional text in the second and fourth paragraphs so that the amended Section 2-3.5 shall read as follows:

2-3.5 Mental Health and Substance Abuse Services

All mental health related services and substance abuse services, unless otherwise specified in this Section 2-3.5, provided to enrollees shall be the responsibility of Behavioral Health Organizations (BHOs) who have a contractual arrangement with the Tennessee Department of Mental Health and Developmental Disabilities or the State. These services include:

- Psychiatric Inpatient Facility Services;
- Physician Psychiatric Inpatient Services;
- Outpatient Mental Health Services;
- Inpatient and Outpatient Substance Abuse Treatment Services;
- Psychiatric Pharmacy Services and Pharmacy Related Lab Services;
- Transportation to Covered Mental Health Services;
- Mental Health Case Management;
- 24-Hour Residential Treatment;
- Housing/Residential Care;
- Specialized Outpatient and Symptom Management;
- Specialized Crisis Services; and
- Psychiatric Rehabilitation Services.

Effective July 1, 2002, behavioral health related services provided to enrollees by an MCO Primary Care Provider shall not be the responsibility of Behavioral Health Organizations (BHOs). As some MCO Primary Care Providers may appropriately treat or manage an enrollee’s behavioral health condition, and in an effort to minimize administrative complexities for those Primary Care Providers (PCPs), the CONTRACTOR shall be responsible for services provided to enrollees by their network PCPs. CONTRACTOR covered services shall also include medical evaluations provided by a neurologist, as approved by the CONTRACTOR, and/or an emergency room physician, that result in a primary behavioral health diagnosis (ICD-9-CM 290.xx - 319.xx). Accordingly, the CONTRACTOR shall direct its network PCPs and approved providers to submit claims for covered services with a primary behavioral diagnosis code, defined as ICD-9-CM 290.xx – 319.xx (and subsequent revisions thereto), to the CONTRACTOR for payment. The CONTRACTOR agrees to timely process said claims in accordance with Section 2-9.7.

The MCO shall encourage its PCPs, at their discretion, to contact the BHO for consultation on any covered Mental Health and Substance Abuse condition/service. The PCPs shall also be encouraged to refer to the BHO, for coordination of treatment of any covered Mental Health and Substance Abuse condition/service, for any and all of its members in accordance with its contracts with TDMHDD when those services can be provided by Mental Health Professionals.

Amendment 6 (continued)

The carve out of mental health and substance abuse services provided by PCPs and/or approved providers from the BHO benefit package shall not relieve the BHO from the responsibility to assist in the coordination of mental health and substance abuse care and medical care of enrollees; nor shall it prohibit PCPs from referring enrollees to a mental health or substance abuse provider in the BHO's network when determined necessary by the PCP.

The CONTRACTOR is responsible for the costs and provision of covered services that are not mental health or substance abuse services, and covered services provided by a network PCP with a primary behavioral health diagnosis code as specified in the preceding paragraph. The carve out of all other mental health and substance abuse services shall not relieve the CONTRACTOR from the responsibility to assist in the coordination of mental health and medical care of enrollees. The MCO and BHO shall assure active coordination between primary health care and mental health/substance abuse care, including case management and continuity of care services. The MCO and BHO shall cooperate with the State's efforts to facilitate delivery of mental health services to the TennCare population and shall agree to abide by the MCO/BHO Coordination Provisions outlined herein for purposes of interfacing with each other and assure coordination of care, case management and continuity of care for purposes of coordinating appropriate health care.

5. Section 2-3.12 shall be amended by deleting the third paragraph so that the amended Section 2-3.p shall read as follows:

2-3.12 Coverage of Organ Transplants

The CONTRACTOR shall cover at a minimum the following transplants: Renal, Heart, Liver, Corneal and Bone Marrow, when medically necessary and consistent with the accepted mode of treatment for which the transplant procedure is performed. The CONTRACTOR shall not cover transplants or procedures, which are not medically necessary or performed for a purpose inconsistent with acceptable modes of treatment. Besides the minimally required transplants, the CONTRACTOR may cover other transplants that are not considered investigational or experimental by the National Institutes of Health and the Tennessee Department of Finance and Administration, if approved by TennCare. For purposes of this Section, investigational or experimental shall mean those transplants and/or procedures which are not considered medically necessary and which have not been approved by the Centers for Medicare & Medicaid Services and published in the Federal Register. Questions as to whether a particular transplant and/or procedure is to be covered shall be directed to the Office of the Medical Director, Bureau of TENNCARE.

Exceptions to the above list of transplants must be made for other non-investigational/non-experimental transplants if the transplant and/or procedure is found to be medically necessary, performed within the accepted mode of treatment for which it is intended, and is found to be cost effective as determined by the CONTRACTOR.

The CONTRACTOR shall establish administrative procedures regarding the necessity of prior approval before a transplant procedure is performed. The CONTRACTOR shall also establish its own administrative procedures regarding the coverage of transplant procedures performed outside the CONTRACTOR's service area as well as transplant procedures performed out-of-state. These administrative procedures shall be submitted to TennCare for review and approval prior to use.

Section 1862 of the Social Security Act requires Medicare beneficiaries to have transplants performed in Medicare certified centers. In accordance with this policy, the CONTRACTOR and Medicare/TennCare dually eligible enrollees shall be required to adhere to these requirements.

6. Sub-items (4)(B), (4)(C), (5)(B), (10) (12), (13) and (27) of Section 2-3.16.8 shall be amended by correcting the contract references so that the amended sub-items (4)(B), (4)(C), (5)(B), (10) (12), (13) and (27) shall read as follows:

Services Listed in Social Security Act Section 1905(a)	Responsible Entity in Tennessee	Comments
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Amendment 6 (continued)

Services Listed in Social Security Act Section 1905(a)	Responsible Entity in Tennessee	Comments
(4)(B) EPSDT services	MCO for physical health services, except as described in Section 2-3.4 and 2-3.5; BHO for mental health and substance abuse services, except as described in Section 2-3.5; Effective October 1, 2002, DBM for dental services except as described in Section 2-3.4; Effective July 1, 2003, PBM for Pharmacy Services as described in Section 2-3.1	
(4)(C)--Family planning services and supplies	MCO; Effective July 1, 2003, PBM for Pharmacy Services as described in Section 2-3.1	
(5)(B)—Medical and surgical services furnished by a dentist	MCO; Effective October 1, 2002, DBM except as described in Section 2-3.4	
(10)—Dental services	MCO; Effective October 1, 2002, DBM except as described in Section 2-3.4	
(12)—Prescribed drugs, dentures, and prosthetic devices, and eyeglasses	MCO for physical health services; TennCare PBM for mental health and substance abuse drugs Effective July 1, 2003, PBM for Pharmacy Services as described in Section 2-3.1 MCO for dentures until October 1, 2002, DBM for dentures thereafter	
(13) Other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services recommended by a physician	MCO for physical health services; BHO for mental health and substance abuse services Effective October 1, 2002, DBM for dental services as	The following are considered practitioners of the healing arts in Tennessee law ¹ : <ul style="list-style-type: none"> • Alcohol and drug abuse counselor • Athletic trainer • Audiologist • Certified acupuncturist

¹ This list has been provided by the Tennessee Department of Health.

Amendment 6 (continued)

<p>or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level</p>	<p>described in Section 2-3.1 and 2-3.4 Effective July 1, 2003, PBM for Pharmacy Services as described in Section 2-3.1</p>	<ul style="list-style-type: none"> • Certified master social worker • Certified nurse practitioner • Certified professional counselor • Certified psychological assistant • Chiropractic physician • Chiropractic therapy assistant • Clinical pastoral therapist • Dentist • Dental assistant • Dental hygienist • Dietitian/nutritionist • Dispensing optician • Electrologist • Emergency medical personnel • First responder • Hearing instrument specialist • Laboratory personnel • Licensed clinical perfusionist • Licensed clinical social worker • Licensed practical nurse • Licensed professional counselor • Marital and family therapist, certified • Marital and family therapist, licensed • Massage therapist • Medical doctor. • Medical doctor (special training) • Midwives and nurse midwives • Nurse aide • Occupational therapist • Occupational therapy assistant • Optometrist • Osteopathic physician • Pharmacist • Physical therapist • Physical therapist assistant • Physician assistant • Podiatrist • Psychological examiner • Psychologist • Registered nurse • Registered certified reflexologist • Respiratory care assistant • Respiratory care technician • Respiratory care therapist • Senior psychological examiner • Speech pathologist • Speech pathology aide • X-ray op in chiropractic physician's office • X-ray op in MD office • X-ray op in osteopathic office • X-ray op in podiatrist's office
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Amendment 6 (continued)

(27) Any other medical care, and any other type of remedial care recognized under State law.	MCO for physical health services; BHO for mental health and substance abuse services Effective October 1, 2002, DBM for dental services as described in Section 2-3.1 and 2-3.4 Effective July 1, 2003, PBM for Pharmacy Services as described in Section 2-3.1	See Item (13).
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7. Section 2-4.1 shall be amended by adding a new sentence to the end of the existing text so that the amended Section 2-4.1 shall read as follows:

2-4.1 Availability and Accessibility of Services

The CONTRACTOR must provide or arrange for the provision of all of the services described as covered in this Agreement. The CONTRACTOR shall make services, service locations, and service sites available and accessible to provide the covered (specialized or otherwise) services. Accessibility shall be in accordance with the Terms and Conditions for Access which is part of the TennCare Waiver and as contained herein as Attachment III unless TENNCARE has specified more stringent access criteria in the Agreement or the Amendments thereto. The CONTRACTOR must provide or arrange for the provision of all the services described as covered in this Agreement.

The CONTRACTOR shall maintain under contract, a provider network including but not limited to primary care physicians, specialist physicians, nurse practitioners/physician assistants, hospitals (all levels primary, secondary and tertiary), centers of excellence, nursing homes, laboratories, pharmacies and all other health care facilities necessary to provide TennCare covered benefits. Should the CONTRACTOR's provider network be unable to provide necessary medical services covered under this Agreement to a particular enrollee, the CONTRACTOR must adequately and timely cover these services out of network for the enrollee, for as long as the entity is unable to provide them. At such time that the required services become available within the CONTRACTOR's network and the enrollee can be safely transferred, the CONTRACTOR may transfer the enrollee to an appropriate contracted service provider.

8. Section 2-4.2.f shall be amended by deleting and replacing the existing reference to Section "2-3.j.3(g)" with Section "2-4.4.h" so that the amended Section 2-4.2.f shall read as follows:

f. Additionally, other vulnerable populations (e.g., persons with special needs such as multiple handicaps, or acute chronic conditions, etc.) may be assigned to a case manager at the MCO level or, at the MCO's discretion, to their attending specialist as their primary care provider. However, the CONTRACTOR shall comply with Section 2-4.4.h regarding enrollees determined to need a course of treatment or regular care monitoring.

9. Section 2-4.10.1.14 shall be deleted and replaced in its entirety so that the amended Section 2-4.10.1.14 shall read as follows:

2.4.10.1.14 Upon termination, cancellation, expiration or other conclusion of the Agreement, and in accordance with Sections 2-11 and 2-13 of this Agreement, the Contractor will, if feasible, return or destroy all PHI, in whatever form or medium (including any electronic medium) and all copies of an any data or compilations derived from and allowing identification of any individual who is a subject of that PHI. The Contractor will complete such return or destruction as promptly as possible, but not later than 30 days after the effective date of the termination, cancellation, expiration or other conclusion of the Agreement, including but not limited to, the provisions in Section 2-11 and 2-13 of this Agreement . The Contractor will identify any PHI that cannot

Amendment 6 (continued)

feasibly be returned to or destroyed. Within such 30 days after the effective date of the termination, cancellation, expiration or other conclusion of the Agreement, including but not limited to, the provisions in Section 2-11 and 2-13 of this Agreement the Contractor will: (1) certify on oath in writing that such return or destruction has been completed; (2) identify any PHI which can not feasibly be returned or destroyed; and (3) certify that it will only use or disclose such PHI for those purposes that make its return or destruction infeasible;

10. Section 2.4.10.1.15 shall be amended by adding a phrase to the end of the existing text so that the amended Section 2.4.10.1.15 shall read as follows:

2.4.10.1.15 The CONTRACTOR shall implement all appropriate administrative, technical and physical safeguards to prevent the use or disclosure of PHI other than pursuant to the terms and conditions of this Agreement, including but not limited to, confidentiality requirements in 45 CFR parts 160 and 164;

11. The first paragraph of Section 2-4.11 shall be deleted and replaced in its entirety so that the amended first paragraph shall read as follows:

The CONTRACTOR and all providers and subcontractors shall not require any cost sharing responsibilities for TennCare covered services except to the extent that cost sharing responsibilities are required for those services by TENNCARE in accordance with TennCare rules and regulations, including but not limited to, holding enrollees liable for debt due to insolvency of the MCO or non-payment by the State to the MCO. Further, the CONTRACTOR and all providers and subcontractors may not charge enrollees for missed appointments.

12. The fifth paragraph of Section 2-4.11 shall be amended by adding the phrase “, including but not limited to, services that the State or the MCO has not paid for” so that the amended fifth paragraph of Section 2-4.11 shall read as follows:

Providers or collection agencies acting on the provider’s behalf may not bill enrollees for amounts other than applicable cost sharing responsibilities for TennCare covered services, including but not limited to, services that the State or the MCO has not paid for, except as permitted by TennCare rule 1200-13-12-.08, 1200-13-13-.08, 1200-13-14-.08 and as described below. Providers may seek payment from an enrollee in the following situations:

13. Section 2-6.4 shall be amended by adding a new Section 2-6.4.6 and renumbering the existing Sections 2-6.4.6 and 7 so that the amended Section 2-6.4 shall read as follows:

2-6.4. Prohibited Marketing and/or Communication Activities

The following information and activities are prohibited:

- 2-6.4. 1. Materials and/or activities that mislead, confuse or defraud or that are unfair or deceptive practices or that otherwise violate federal or state consumer protection laws or regulations. This includes materials which mislead or falsely describe covered or available services, membership or availability of network providers, and qualifications and skills of network providers. Further the CONTRACTOR shall adhere to requirements for the written materials to assure that material is accurate and does not mislead, confuse or defraud the recipients or the state agency and materials shall be subject to review by the Medical Care Advisory Committee (MCAC);
- 2-6.4. 2. Overly aggressive solicitation, such as repeated telephoning or continued recruitment after an offer for enrollment is declined by an enrollee, or similar techniques;
- 2-6.4. 3. Gifts and offers of material or financial gain as incentives to enroll;

Amendment 6 (continued)

- 2-6.4. 4. Compensation arrangements with marketing personnel that utilize any type of payment structure in which compensation is tied to the number of persons enrolled;
- 2-6.4. 5. Direct solicitation of prospective enrollees;
- 2-6.4. 6. Directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities;
- 2-6.4. 7. In accordance with federal requirements, independent marketing agents shall not be used in connection with marketing activities. Independent marketing agents shall not mean staff necessary to develop or produce marketing materials or advertising or other similar functions;
- 2-6.4. 8. In accordance with federal requirements, the CONTRACTOR shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance.
14. The first sentence of Section 2-6.6.6 shall be amended by adding the phrase “any enrollee who needs such services, including but not limited to,” so that the amended Section 2-5.f.6 shall read as follows:
6. The CONTRACTOR shall develop a written procedure for the provision of language interpretation and translation services for any enrollee who needs such services, including but not limited to, enrollees with Limited English Proficiency. The CONTRACTOR shall provide instruction for its staff and all direct service sub-contractors regarding the procedure.
15. Section 2-8 shall be amended by adding new text to the existing Section 2-8.1.10, adding a new Section 2-8.1.11 and renumbering the existing Section 2-8.1.11 as 2-8.1.12 so that the amended Sections 2-8.1.10 and 11 shall read as follows:
- 2-8.1.10. Except for initial reconsideration by an MCO, as permitted under the TennCare rules, no person who is an employee, agent or representative of an MCO may participate in deciding the outcome of a TennCare appeal. No state official may participate in deciding the outcome of a beneficiary's appeal who was directly involved in the initial determination of the action in question. The State will ensure that decision makers on grievances and appeals were not involved in previous levels of review or decision-making and who are health care professionals with clinical expertise in treating the enrollee's condition or disease if any of the following apply:
- a denial appeal based on lack of medical necessity.
 - a grievance regarding denial of expedited resolutions of an appeal.
 - any grievance or appeal involving clinical issues.
- The Contractor shall keep a record of who reviews each reconsideration. The State will monitor compliance with this provision. Further, for purposes of assuring timeliness and appropriateness of the provision of services in accordance with Section 4-8.b.2, an MCOs reconsideration to provide services shall be considered the same as a directive to do so by TENNCARE.
- 2-8.1.11 TENNCARE and/or the CONTRACTOR shall not prohibit or discourage any individual from testifying on behalf of an enrollee.
16. Section 2-14 shall be deleted and replaced in its entirety so that the amended Section 2-14 shall read as follows:

2-14 Independent Review of the CONTRACTOR

In accordance with Chapter 4 of the waiver approved by the Centers for Medicare and Medicaid Services (CMS), CMS may select a PRO, Private Accreditation Organization or an External Quality Review Organization (EQRO) to provide a periodic or an annual independent review of the CONTRACTOR. The results of the review shall be

Amendment 6 (continued)

provided to TENNCARE and to the CONTRACTOR and shall be available, on request, to the Department of Health and Human Services, the Office of Inspector General and General Accounting Office. TENNCARE shall be responsible for issuing the Request For Proposal (RFP) and selecting the PRO or EQRO.

17. Section 2-17.a shall be amended by adding the phrase "on at least an annual basis" to item 3. and adding a new item 5 so that the amended Section 2-17.a shall read as follows:

a. Subcontract Relationships and Delegation. If the CONTRACTOR delegates responsibilities to a subcontractor, the CONTRACTOR shall assure that the subcontracting relationship and subcontracting document(s) comply with the requirements of the Balanced Budget Act of 1997, including, but not limited to, compliance with the applicable provisions of 42 CFR 438.230(b) and 42 CFR 434.6 as described below:

1. The CONTRACTOR shall evaluate the prospective subcontractor's ability to perform the activities to be delegated.
2. The CONTRACTOR shall require that the agreement be in writing and specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.
3. The CONTRACTOR shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review, on at least an annual basis, consistent with industry standards or State MCO laws and regulations.
4. The CONTRACTOR shall identify deficiencies or areas for improvement and the CONTRACTOR and the subcontractor shall take corrective action as necessary.
5. If the subcontract is for purposes of providing or securing the provision of covered services to enrollees, the CONTRACTOR shall ensure that all requirements described in Section 2-18 of this Agreement are included in the subcontract and/or a separate provider agreement executed by the appropriate parties.

18. Section 2-17.f shall be deleted and replaced in its entirety so that the amended Section 2-17.f shall read as follows:

f. Interpretation/Translation Services and LEP Provisions. The CONTRACTOR shall provide instruction for all direct service sub-contractors regarding the CONTRACTOR's written procedure for the provision of language interpretation and translation services for any enrollee who needs such services, including but not limited to, enrollees with Limited English Proficiency.

19. Second paragraph of Section 2-18 shall be amended by adding a reference to "S-Chip" so that the amended second paragraph shall read as follows:

Provider agreements do not require prior approval by TENNCARE before taking effect; however, the CONTRACTOR shall not execute provider agreements with providers who have been excluded from participation in the Medicare, Medicaid, and/or S-Chip programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with the TENNCARE program. Further, all template provider agreements and revisions thereto must be approved in advance by the TennCare Division, Department of Commerce and Insurance in accordance with statutes regarding the approval of an HMOs certificate of authority (COA) and any material modifications thereof.

20. Section 2-18 shall be amended by adding a new section 2-18.ss which shall read as follows:

Amendment 6 (continued)

2-18.ss Specify instruction that the provider have written procedures for the provision of language interpretation and translation services for any enrollee who needs such services, including but not limited to, enrollees with Limited English Proficiency.

21. The first sentence of Section 2-24.b shall be amended by adding the phrase “any enrollee who needs such services, including but not limited to,” so that the amended Section 2-24.b shall read as follows:

2-24.b. The CONTRACTOR shall develop a written procedure for the provision of language interpretation and translation services for any enrollee who needs such services, including but not limited to, enrollees with Limited English Proficiency. The CONTRACTOR shall provide instruction for its staff, including but not limited to, the designated staff person for Title VI, and all providers and direct service sub-contractors regarding the procedure.

22. The first paragraph of Section 6-1 shall be deleted and replaced in its entirety so that the amended first paragraph of Section 6-1 shall read as follows:

6-1 Applicable Laws and Regulations

The CONTRACTOR agrees to comply with all applicable federal and state laws, rules and regulations, TennCare Standard Operating Procedures (so long as said TennCare Standard Operating Procedure does not constitute a material change to the obligations of the Contractor pursuant to this Agreement), and court orders, including Constitutional provisions regarding due process and equal protection of the laws including but not limited to:

23. Section 6-8.1 shall be deleted and replaced in its entirety so that the amended Section 6-8.1 shall read as follows:

6-8.1 Intermediate Sanctions

TENNCARE may impose any or all of the sanctions as described in Section 6 upon TENNCARE’s reasonable determination that the CONTRACTOR fails to comply with any corrective action plan (CAP) as described under Section 2-16 is otherwise deficient in the performance of its obligations under the Agreement, which shall include, but may not be limited to the following:

- Fails substantially to provide medically necessary services that the MCO is required to provide, under law or under this Agreement to an enrollee covered under the Agreement.
- Imposes on enrollees cost share responsibilities that are in excess of the cost share responsibilities permitted by TENNCARE.
- Acts to discriminate among enrollees on the basis of their health status or need for health care services.
- Misrepresents or falsifies information that it furnishes to CMS or to the State.
- Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider.
- Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 CFR 422.208 and 422.210.
- Has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information.
- Has violated any of the other applicable requirements of sections 1903(m) or 1932 of the Act and any implementing regulations.
- Has violated any of the other applicable requirements of sections 1932 or 1905(t)(3) of the Social Security Act and any implementing regulations.

TENNCARE shall only impose those sanctions it determines to be appropriate for the deficiencies identified. However, TENNCARE may impose intermediate sanctions on the CONTRACTOR simultaneously with the development and implementation of a corrective action plan if the deficiencies are severe or numerous.

Amendment 6 (continued)

Intermediate sanctions may include:

1. application of liquidated damages as described in Section 6-2;
 2. suspension of enrollment in the CONTRACTOR's MCO as described in Section 2-16;
 3. disenrollment of enrollees as described in Section 2-22 and 4; or
 4. limitation of the CONTRACTOR's Service Area as described in Section 2-22 and 4.
 5. Civil monetary penalties in as described in 42 CFR 438.704;
 6. Appointment of temporary management for an MCO as provided in 42 CFR 438.706.
 7. Granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to disenroll.
 8. Suspension of all new enrollment, including default enrollment, after the effective date of the sanction.
 9. Suspension of payment for recipients enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur; or
 10. Additional sanctions allowed under state statute or regulation that address areas of noncompliance.
24. Section 6-8 shall be amended by replacing the references to Sections 6-8.c and 6-8.d with Sections 6-8.3 and 6-8.4 to be consistent with the numbering of other subparts of Section 6-8 of this Agreement.
25. Section 6-26 shall be amended by deleting and replacing the date "December 31, 2003" with "December 31, 2004" so that the amended Section 6-26 shall read as follows:

6-26 Contract Term of The Agreement

This Agreement and its incorporated attachments, if any, as well as all Amendments to this Agreement, contain all of the terms and conditions agreed upon by the parties, and when executed by all parties, supersedes any prior agreements. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall be in effect from July 1, 2001, subject to approval by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The term of this Agreement shall expire on December 31, 2004. At the mutual agreement of TennCare and the CONTRACTOR, this CONTRACT shall be renewable for an additional twelve month period.

Notwithstanding any provision herein to the contrary, the State may terminate this Agreement if the waiver governing TennCare is terminated. The documents referenced in the Agreement are on file with the CONTRACTOR and with TENNCARE and the CONTRACTOR is aware of their content. No other agreement, oral or otherwise regarding the subject matter of this Agreement, shall be deemed to exist or to bind any of the parties hereto.

26. The reference to "Section 2-3.a.1" in this Section 7-3.d shall be deleted and replaced with the appropriate reference to "Section 2-3.1" so that the amended Section 7-3.d shall read as follows:
- 7-3.d. Drug formulary and all subsequent changes (applicable only if a closed formulary). Effective July 1, 2003, TENNCARE shall contract directly with a pharmacy benefits manager (PBM) for the provision of pharmacy services as described in Section 2-3.1 of this Agreement;
27. Section 7-7 shall be amended by adding a new third sentence so that the amended Section 7-7 shall read as follows:

7-7 Enrollment, Disenrollment and Eligibility Verification

TENNCARE shall be responsible for the receipt of applications for TennCare eligibility, verification of the data contained on the application, determination of the applicability of cost sharing amounts and collection of applicable premiums. TENNCARE shall also be responsible for enrollment of eligible persons in the CONTRACTOR'S plan and for disenrollment of ineligible persons from the CONTRACTOR'S plan. In accordance with federal requirements, if TENNCARE fails to make a decision within the required timeframes, the request shall be considered approved. All TENNCARE approved disenrollment terminations shall be effective on or before the first day of the second month following the month of an enrollee's request to terminate from an MCO. Unless otherwise requested by an enrollee, TENNCARE shall provide for automatic reenrollment of an enrollee who is disenrolled solely because he or she loses eligibility for a period of 2 months or less. TENNCARE will arrange for the CONTRACTOR to have updated eligibility information in the form of on-line computer access and will notify the CONTRACTOR when TENNCARE determines that an enrollee has moved. TENNCARE may provide the CONTRACTOR with a report containing enrollees for whom TENNCARE has been unable to locate or verify various types of pertinent information. Upon receipt of this report, the CONTRACTOR shall provide TENNCARE with any information that is known by the CONTRACTOR that may affect an enrollee's TennCare eligibility and/or cost sharing responsibilities including changes in income, family size, access to health insurance, proof of uninsurability, including limited coverage and exclusionary riders to policies, change of residence or residence outside the State of Tennessee.

TENNCARE shall not enroll applicants as the result of enrollment applications submitted by a CONTRACTOR or anyone acting on its behalf.

In accordance with Section 2-22 of this Agreement, TENNCARE has authorized the CONTRACTOR to serve one or more community service areas within a Grand Region. TENNCARE shall maintain the flexibility to freeze enrollment, or begin disenrollment in one or more area(s) of the CONTRACTOR's plan if TENNCARE determines it to be in the best interest of enrollees, the CONTRACTOR's plan and/or the TennCare program. However, during such periods that TENNCARE has suspended enrollment in an area(s), TENNCARE shall maintain the flexibility to allow enrollees to continue to be enrolled in such areas when; 1) the enrollee is a member of the same household that is currently in the CONTRACTOR's plan, 2) it is determined necessary by TENNCARE due to an emergent or hardship case, or 3) the enrollee had requested enrollment in the CONTRACTOR's plan prior to closure of additional enrollment.

28. Section 7-11.d and 7-11.e shall be amended by deleting and replacing the references to "Sections 2-3.a.1 and 2-3.c.3" with the appropriate references "Sections 2-3.1 and 2-3.4" so that the amended Sections 7-11.d and e shall read as follows:
- d. Effective October 1, 2002, dental services as described in Sections 2-3.1 and 2-3.4 of this Agreement; and
 - e. Effective July 1, 2003, all TennCare pharmacy benefits as described in Section 2-3.1 of this Agreement.
29. Items E and J of Part I of Attachment I shall be amended by deleting and replacing the reference to "Section 2-3.a.1: with the appropriate reference to "Section 2-3.1" so that the amended Items E and J shall read as follows:
- E. Drug Formulary (if closed) (Effective July 1, 2003, the TENNCARE shall contract directly with a pharmacy benefits manager for pharmacy services as described in Section 2-3.1 of this Agreement.) TENNCARE has thirty (30) calendar days to respond

Amendment 6 (continued)

- J. Method of pharmacy restriction procedures for Pharmacy Abusers Effective July 1, 2003, the TENNCARE shall contract directly with a pharmacy benefits manager for pharmacy services as described in Section 2-3.1 of this Agreement At such time, the CONTRACTOR shall comply with TennCare Policy regarding Pharmacy Abusers. TENNCARE has thirty (30) calendar days to respond

30. Item C of Part II of Attachment I shall be amended by deleting and replacing the reference to "Section 2-3.a.1" with the appropriate reference to "Section 2-3.1" so that the amended Item C shall read as follows:

- C Complete Drug Formulary; if CONTRACTOR utilizes a closed drug formulary, and a complete description of prior authorization criteria for each drug requiring prior authorization via electronic file in accordance with Section 3-13 January 1 of each year to TENNCARE Pharmacy Director

(Effective July 1, 2003, the TENNCARE shall contract directly with a pharmacy benefits manager for pharmacy services as described in Section 2-3.1 of this Agreement.)

31. Part II of Attachment I shall be amended by deleting Item G in its entirety and renumbering the existing items.
32. Attachment II, Standard II.C.5 shall be amended by adding a new sentence to the end of the existing text so that the amended Attachment II, Standard II.C.5 shall read as follows:
5. The standards/guidelines shall be included in provider manuals developed for use by managed care providers or otherwise disseminated to providers as they are adopted. The MCO must disseminate, upon request, the guidelines to enrollees and potential enrollees.
33. Attachment II, Standard X.A shall be amended by adding new items 8, 9, and 10 which shall read as follows:
8. to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;
9. to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation; and
10. to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO or its providers or the State agency treat the enrollee.
34. Attachment II, Standard XIV.C.2 shall be amended by adding a new sentence to the end of the existing text so that the amended Attachment II, Standard XIV.C.2 shall read as follows:

Amendment 6 (continued)

2. **Preauthorization and concurrent review decisions are supervised by qualified medical professionals who have appropriate clinical expertise in treating the enrollee's condition or disease.**

Amendment 6 (continued)

All of the provisions of the original Agreement not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective January 1, 2004 or as of the date it is approved by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: *M. D. Goetz, Jr.*
M. D. Goetz, Jr.
Commissioner

DATE: 12/23/03

VOLUNTEER STATE HEALTH PLAN,
INC.

BY: *Ronald E. Harr*
Ron E. Harr
President and Chief Executive Officer

DATE: Dec 23, 2003

APPROVED BY:

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: *M. D. Goetz, Jr.*
M. D. Goetz, Jr.
Commissioner

DATE: JAN 07 2004
JAN 07 2004

APPROVED BY:

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

BY: *John G. Morgan*
John G. Morgan
Comptroller

DATE: 1/9/04

CONTRACT SUMMARY SHEET

RFS Number:	318.66-026	Contract Number:	FA-02-14632-05
State Agency:	Department of Finance and Administration	Division:	Bureau of TennCare

Contractor	Contract Identification Number
VSHP (TennCare Select)	<input type="checkbox"/> V- <input type="checkbox"/> C-

Service Description

Managed Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medicaid Population

Contract Begin Date	Contract End Date
7/1/2001	12/31/2003

Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66	839	134	11	<input type="checkbox"/> STARS		
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (Including ALL amendments)	
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$ 18,599,868.48	
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$ 33,079,942.80	
2004	\$ 13,004,375.09	\$ 16,390,807.53			\$ 29,395,182.62	
Total:	\$ 35,545,435.72	\$ 45,529,558.18			\$ 81,074,993.90	

OCR RELEASED
DEC 15 2003

CFDA#	93.778	TO ACCOUNTS	Check the box ONLY if the answer is YES:
State Fiscal Contract		Is the Contractor a SUBRECIPIENT? (per OMB A-133)	<input type="checkbox"/>
Name:	Dean Daniel	Is the Contractor a Vendor? (per OMB A-133)	<input type="checkbox"/>
Address:	729 Church Street Nashville, TN	Is the Fiscal Year Funding STRICTLY LIMITED?	<input type="checkbox"/>
Phone:	(615)532-1362	Is the Contractor on STARS?	<input type="checkbox"/>
Procuring Agency Budget Officer Approval Signature		Is the Contractor's FORM W-9 ATTACHED?	<input type="checkbox"/>
Dean Daniel	<i>Dean Daniel</i> 12/11/03	Is the Contractor's Form W-9 Filed with Accounts?	<input type="checkbox"/>

COMPLETE FOR ALL AMENDMENTS (only)			Funding Certification	
	Base Contract & Prior Amendments	This Amendment ONLY	Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred. <i>Budget 12-9-03</i>	
CONTRACT END DATE:				
FY: 2002	\$ 18,599,868.48			
FY: 2003	\$ 33,079,942.80			
FY: 2004	\$ 24,372,429.50	\$ 5,022,753.12		
FY:				
FY:				
Total:	\$ 76,052,240.78	\$ 5,022,753.12		

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 2003 DEC 12 AM 11:26
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 COMPTROLLER'S OFFICE
 OF
 MANAGEMENT SERVICES

AMENDMENT NUMBER 5

AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.

CONTRACT NUMBER: FA-02-14632-0500 *MOB/2*

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as follows:

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. Section 2 of the Agreement for the Administration of TennCare Select shall be amended by deleting and replacing Section 2-25 which shall read as follows:

2-25. Processing and Payment of Supplemental Payments

Subject to the availability of State and Federal funding, the CONTRACTOR agrees to make supplemental pool payments to Meharry Medical Services Foundation or Meharry Dental Clinic, as directed by TENNCARE. These payments represent unreimbursed TennCare costs of the Meharry Medical College clinics as determined by a review of an independent CPA and in accordance with the methodology approved by the Centers for Medicare and Medicaid Services. Clinical services are performed by Meharry Medical College faculty physicians through the Meharry Dental Clinic and the Meharry Medical Services Foundation. The payment by the CONTRACTOR to the clinic(s) will be made within 10 calendar days of the receipt of such payment by the CONTRACTOR from TENNCARE. The CONTRACTOR may deposit these funds in the account of its choice and may retain all interest earned as compensation for providing this service. The CONTRACTOR agrees to include any correspondence requested by TENNCARE to be included with the payment and provide a written confirmation of any disbursements including the date the check was mailed and the date redeemed.

Payments to the Meharry Medical Services Foundation and/or the Meharry Dental Clinic under this amendment shall not exceed \$4,942,107 for State fiscal year 2003. In addition to any interest earned, TENNCARE agrees to pay the CONTRACTOR a sum sufficient to administer this amendment in accordance with state law. The total obligation to the CONTRACTOR under this amendment including the supplemental payment to Meharry Medical Services Foundation and/or the Meharry Dental Clinic shall not exceed \$5,042,966 for State fiscal year 2003.

Payments to the Meharry Medical Services Foundation and/or the Meharry Dental Clinic under this amendment shall not exceed \$4,922,298.00 for State fiscal year 2004. In addition to any interest earned, TENNCARE agrees to pay the CONTRACTOR a sum sufficient to administer this amendment in accordance with state law. The total obligation to the CONTRACTOR under this amendment including the supplemental payment to Meharry Medical Services Foundation

Amendment 5 (continued)

and/or the Meharry Dental Clinic shall not exceed \$5,022,753.12 for State fiscal year 2004. At such time that Federal Regulations allow, TENNCARE may discontinue making supplemental pool payments through the CONTRACTOR during State fiscal year 2004.

All of the provisions of the original Agreement not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective as of the date it is approved by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: M.D. Goetz, Jr.
M. D. Goetz, Jr.
Commissioner

DATE: 12/2/03

VOLUNTEER STATE HEALTH PLAN,
INC.

BY: Ronald E. Harr
Ronald E. Harr
President and Chief Executive Officer

DATE: Nov. 20, 2003

APPROVED BY:

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: M. D. Goetz, Jr.
M. D. Goetz, Jr.
Commissioner

DATE: 12/9/03

APPROVED BY:

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

BY: John G. Morgan
John G. Morgan
Comptroller

DATE: 12-15-03

MEHARRY MONTHLY POOL PAYMENTS

Demo Year 02, SFY 03-04

	State's Monthly Appropriation	MCO Pymts with Tax	Monthly 2% Tax
July 2003	\$ 410,191.50	\$ 418,562.76	\$ 8,371.26
August	\$ 410,191.50	\$ 418,562.76	\$ 8,371.26
September	\$ 410,191.50	\$ 418,562.76	\$ 8,371.26
October	\$ 410,191.50	\$ 418,562.76	\$ 8,371.26
November	\$ 410,191.50	\$ 418,562.76	\$ 8,371.26
December	\$ 410,191.50	\$ 418,562.76	\$ 8,371.26
January 2004	\$ 410,191.50	\$ 418,562.76	\$ 8,371.26
February	\$ 410,191.50	\$ 418,562.76	\$ 8,371.26
March	\$ 410,191.50	\$ 418,562.76	\$ 8,371.26
April	\$ 410,191.50	\$ 418,562.76	\$ 8,371.26
May	\$ 410,191.50	\$ 418,562.76	\$ 8,371.26
June	\$ 410,191.50	\$ 418,562.76	\$ 8,371.26
	<u>\$ 4,922,298.00</u>	<u>\$ 5,022,753.12</u>	<u>\$ 100,455.12</u>

CONTRACT SUMMARY SHEET

RFS Number: 318.66 - 026		Contract Number: FA-02-14632-04			
State Agency: Department of Finance and Administration		Division: Bureau of TennCare			
Contractor		Contract Identification Number			
VSHP (TennCare Select)		<input type="checkbox"/> V- <input type="checkbox"/> C-			
Service Description					
Managed Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medicaid Population					
Contract Begin Date		Contract End Date			
7/1/2001		12/31/2003			
Allotment Code	Cost Center	Object Code	Fund		
318.66	839	134	11		
		<input type="checkbox"/> STARS			
FY	State Funds	Federal Funds	Interdepartmental Funds		
2002	\$ 6,755,937.23	\$ 11,843,931.25			
2003	\$ 15,785,123.40	\$ 17,294,819.40			
2004	\$ 11,153,919.98	\$ 13,218,509.53			
Total:		\$ 33,694,980.61	\$ 42,357,260.18		
CFDA#		93.778			
State Fiscal Contract		Check the box ONLY if the answer is YES:			
Name: Dean Daniel		Is the Contractor a SUBRECIPIENT? (per OMB A-133)			
Address: 729 Church Street		Is the Contractor a Vendor? (per OMB A-133)			
Phone: (615)532-1362		Is the Fiscal Year Funding STRICTLY LIMITED?			
Procuring Agency Budget Officer Approval Signature		Is the Contractor on STARS?			
Dean Daniel <i>Dean Daniel 11/14/03</i>		Is the Contractor's FORM W-9 ATTACHED?			
		Is the Contractor's Form W-9 Filed with Accounts?			
COMPLETE FOR ALL AMENDMENTS (only)		Funding Certification			
		Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.			
CONTRACT END DATE:				Base Contract & Prior Amendments	This Amendment ONLY
FY: 2002	\$ 18,599,868.48				
FY: 2003	\$ 33,079,942.80				
FY: 2004	\$ 18,366,944.50			\$ 6,005,485.00	
Total:		\$ 70,046,755.78	\$ 6,005,485.00		

AMENDMENT NUMBER 4

AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.

CONTRACT NUMBER: FA-02-14632-05 ⁰⁰ MDS/ujt

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as follows:

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. Section 2 of the Agreement for the Administration of TennCare Select shall be amended by adding Section 2-26 which shall read as follows:

2-26. Processing and Payment of Critical Access Hospital Payments

Subject to the availability of State and Federal funding, the CONTRACTOR agrees to make payments to certain hospitals designated as critical access hospitals based on a schedule to be provided by TennCare. These payments are being made in accordance with the methodology approved by the Centers for Medicare and Medicaid Services, which appears as Amendment 2 to the State's Operational Protocol. The payment by the CONTRACTOR to the hospital(s) will be made within 10 calendar days of the receipt of such payment by the CONTRACTOR from TENNCARE. The CONTRACTOR may deposit these funds in the account of its choice and may retain all interest earned as compensation for providing this service. The CONTRACTOR agrees to include any correspondence requested by TENNCARE to be included with the payment and provide a written confirmation of any disbursements including the date the check was mailed and the date redeemed.

Payments to the critical access hospitals under this amendment shall not exceed \$4,708,300 for State fiscal year 2003. In addition to any interest earned, TENNCARE agrees to pay the CONTRACTOR a sum sufficient to administer this amendment in accordance with state law. The total obligation to the CONTRACTOR under this amendment including the payments to the hospitals shall not exceed \$4,804,388 for State fiscal year 2003.

Payments to the critical access hospitals under this amendment shall not exceed \$4,708,300 for State fiscal year 2004. In addition to any interest earned, TENNCARE agrees to pay the CONTRACTOR a sum sufficient to administer this amendment in accordance with state law. The total obligation to the CONTRACTOR under this amendment including the payments to the hospitals shall not exceed \$4,804,388 for State fiscal year 2004. At such time that Federal Regulations allow, TENNCARE may discontinue making supplemental pool payments through the CONTRACTOR during State fiscal year 2004.

Amendment 5 (continued)

All of the provisions of the original Agreement not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective as of the date it is approved by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: *M. D. Goetz, Jr.*
M. D. Goetz, Jr.
Commissioner

DATE: 11/5/03

VOLUNTEER STATE HEALTH PLAN,
INC.

BY: *Ronald E. Harr*
Ronald E. Harr
President and Chief Executive Officer

DATE: Oct. 27, 2003

APPROVED BY:

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: *M. D. Goetz, Jr.*
M. D. Goetz, Jr.
Commissioner

DATE: NOV 14 2003

APPROVED BY:

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

BY: *John G. Morgan*
John G. Morgan
Comptroller

DATE: 11/14/03

CONTRACT SUMMARY SHEET

RFS Number:	318-66-026	Contract Number:	FA-02-14632-03
State Agency:	Department of Finance and Administration	Division:	Bureau of TennCare

Contractor	Contract Identification Number
VSHP (TennCare Select)	<input type="checkbox"/> V- <input type="checkbox"/> C-

Service Description

Managed Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medicaid Population

Contract Begin Date	Contract End Date
7/1/2001	12/31/2003

Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66	839	134	11	<input type="checkbox"/> STARS		
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)	
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$ 18,599,868.48	
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$ 33,079,942.80	
2004	\$ 9,183,472.25	\$ 9,183,472.25			\$ 18,366,944.50	
Total:	\$ 31,724,532.88	\$ 38,322,222.90			\$ 70,046,755.78	

CFDA#	93.778	Check the box ONLY if the answer is YES:
State Fiscal Contract		<input type="checkbox"/> Is the Contractor a SUBRECIPIENT? (per OMB A-133)
Name:	Dean Daniel	<input type="checkbox"/> Is the Contractor a Vendor? (per OMB A-133)
Address:	729 Church Street	<input type="checkbox"/> Is the Fiscal Year Funding STRICTLY LIMITED?
Phone:	Nashville, TN (615)532-1362	

Procuring Agency Budget Officer Approval Signature	<input type="checkbox"/> Is the Contractor on STARS?
Dean Daniel <i>Dean Daniel</i> 6/30/03	<input type="checkbox"/> Is the Contractor's FORM W-9 ATTACHED?
	<input type="checkbox"/> Is the Contractor's Form W-9 Filed with Accounts?

COMPLETE FOR ALL AMENDMENTS (only)			Funding Certification
	Base Contract & Prior Amendments	This Amendment ONLY	Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.
CONTRACT END DATE:			
FY: 2002			
FY: 2003			
FY: 2004			
FY:			
Total:	\$ -	\$ -	

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 COMPTROLLER'S OFFICE
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 JUL 01 2003
 Office of Contracts Review

CONTRACT SUMMARY SHEET

FS Number:	318-66-026	Contract Number:	FA-02-14632-03
State Agency:	Department of Finance and Administration	Division:	Bureau of TennCare

Contractor	Contract Identification Number
<input checked="" type="checkbox"/> SHP (TennCare Select) <input type="checkbox"/> V- <input type="checkbox"/> C-	

Service Description

Managed Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medicaid Population

Contract Begin Date	Contract End Date
7/1/2001	12/31/2003

Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66	839	134	11	<input type="checkbox"/> STARS		
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)	
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$	18,599,868.48
2003	\$ 14,018,488.40	\$ 14,018,488.40			\$	28,036,976.80
2004	\$ 9,183,472.25	\$ 9,183,472.25			\$	18,366,944.50
Total:	\$ 29,957,897.88	\$ 35,045,891.90			\$	65,003,790.78

CFDA#	93.778	Check the box ONLY if the answer is YES:
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State Fiscal Contract		
Name:	Dean Daniel	Is the Contractor a SUBRECIPIENT? (per OMB A-133)
Address:	729 Church Street	Is the Contractor a Vendor? (per OMB A-133)
Phone:	Nashville, TN (615)532-1362	Is the Fiscal Year Funding STRICTLY LIMITED?

Procuring Agency Budget Officer Approval Signature	
Dean Daniel	<i>Dean Daniel 6/30/03</i>
	Is the Contractor on STARS?
	Is the Contractor's FORM W-9 ATTACHED?
	Is the Contractor's Form W-9 Filed with Accounts?

COMPLETE FOR ALL AMENDMENTS (only)			Funding Certification	
	Base Contract & Prior Amendments	This Amendment ONLY	Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.	
CONTRACT END DATE:				
FY: 2002				
FY: 2003				
FY: 2004				
FY:				
Total:	\$ -	\$ -		

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JUN 30 2003

Office of Contracts Review

AMENDMENT NUMBER 3

**AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.**

CONTRACT NUMBER: FA-02-14632-03

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Amended and Restated Contractor Risk Agreement by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as follows:

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. Section 1-1 shall be amended by deleting "Mark Austin" and inserting "Nancy Reykdal" so that the title and address for the notice to TENNCARE shall read as follows:

If to TENNCARE:

Deputy Commissioner
Bureau of TennCare
729 Church Street
Nashville, Tennessee 37247-6501

If to the CONTRACTOR:

Nancy Reykdal
Vice President
801 Pine Street
Chattanooga, Tennessee 37402-2555

1. The definition of "Appeal Procedure" in Section 1-3 shall be amended by adding the references "1200-13-13-.11" and "1200-13-14-.11" so that the amended definition of "Appeal Procedure" shall read as follows:

Appeal Procedure - The process to resolve an enrollee's right to contest verbally or in writing, any adverse action taken by the CONTRACTOR to deny, reduce, terminate, delay, or suspend a covered service as well as any other acts or omissions of the CONTRACTOR which impair the quality, timeliness or availability of such benefits. The appeal procedure shall be governed by TennCare rules 1200-13-12-.11, 1200-13-13-.11, 1200-13-14-.11 and any and all applicable court orders. Complaint shall mean an enrollee's right to contest any other action taken by the CONTRACTOR or service provider other than those that meet the definition of an adverse action.

2. The definition of "Medically Necessary" in Section 1-3 shall be amended by deleting the words "TennCare Medicaid" in item "e" so that the amended definition for "Medically Necessary" shall read as

described below. At such time that TENNCARE implements different benefit packages for Medicaid and Standard enrollees that does not include EPSDT benefits for Standard eligibles, the words "TennCare Medicaid" shall be replaced in item "e".

Medically Necessary - Services or supplies provided by an institution, physician, or other provider that are required to identify or treat a TennCare enrollee's illness, disease, or injury and which are:

- a. Consistent with the symptoms or diagnosis and treatment of the enrollee's illness, disease, ailment, or injury; and
- b. Appropriate with regard to standards of good medical practice; and
- c. Not solely for the convenience of an enrollee, physician, institution or other provider; and
- d. The most appropriate supply or level of services which can safely be provided to the enrollee. When applied to the care of an inpatient, it further means that services for the enrollee's medical symptoms or condition require that the services cannot be safely provided to the enrollee as an outpatient; and
- e. When applied to enrollees under 21 years of age, services shall be provided in accordance with EPSDT requirements including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.

- 3. Section 1-3 shall be amended by amending the definition of "Post-stabilization Care Services" to insert the phrase "to maintain the stabilized condition" and by adding a new definition for "Enrollees with Special Health Care Needs" so that the amended definition for "Post-stabilization Care Services" and the new definition for "Enrollees with Special Health Care Needs" shall read as follows:

Post-stabilization Care Services - Non-emergency services subsequent to an emergency that a treating physician views as medically necessary to maintain the stabilized condition after an emergency medical condition has been stabilized.

Enrollees with Special Health Care Needs - For purposes of requirements in Sections 2-3.j.2(l) and (m) of this Agreement, enrollees with special health care needs shall refer to enrollees in state custody through the Department of Children's Services (DCS).

- 4. Section 2-1.k shall be deleted in its entirety and replaced by a new Section 2-1.k which shall read as follows:

2-1.k. The CONTRACTOR shall demonstrate that it maintains health information systems that collects, analyzes, integrates, and reports data. The systems must provide information on areas applicable to the MCOs contractual requirements including, but not limited to, utilization, grievances and appeals and disenrollments. To the extent agreed upon by both parties and allowable by law, the CONTRACTOR agrees to provide TENNCARE online, read-only, real-time access to the information housed within the CONTRACTOR's information system to access the CONTRACTOR's TennCare data in a mutually agreed upon format and within a timeframe agreed upon by TENNCARE. TENNCARE and the CONTRACTOR shall work together to develop appropriate mechanisms to accomplish this requirement.

5. The Pharmacy Services description and lead in titles to Sections 2-3.1.1, 2, and 3 shall be deleted in their entirety and replaced by new Pharmacy Services descriptions and lead in titles which shall read as follows:

2-3.1.1 TennCare Benefits, prior to notification by TENNCARE to implement separate Medicaid/Standard Benefits:

SERVICE	BENEFIT
<p>Pharmacy Services (obtained directly from an ambulatory retail pharmacy setting, outpatient hospital pharmacy, mail order pharmacy or those administered to a long-term care facility resident (nursing facility))</p>	<p>As medically necessary. Non-covered therapeutic classes as described in Section 2-3.13, DESI, LTE, IRS drugs excluded.</p> <p>TENNCARE is responsible for the provision and payment of pharmacy benefits to individuals who are enrolled in the TennCare Program in the category of TennCare Medicaid/Medicare dual eligible. (However, this does not include pharmaceuticals administered in a doctor's office.)</p> <p>TENNCARE is not responsible for the provision and payment of pharmacy services for TennCare Medicaid/Medicare dual eligibles prior to the date that TENNCARE has notified the CONTRACTOR through the regular electronic eligibility update that these individuals are eligible in the TennCare/Medicare dual eligible category.</p> <p>Effective July 1, 2003, the aforementioned covered pharmacy services shall be provided by the Pharmacy Benefits Manager (PBM) contracted by the TENNCARE Bureau.</p> <p>Diabetic monitors and supplies as well as home infusion and injectable drugs obtained directly from a pharmacy provider shall be included in the covered pharmacy services that will be provided by the TennCare Pharmacy Benefit Manager effective July 1, 2003.</p> <p>In order to minimize disruption of current service delivery arrangements that may be outside of a CONTRACTOR's PBM arrangement, the CONTRACTOR may continue to reimburse home infusion and injectable drugs through its current arrangement.</p>

2-3.1.2 TennCare Medicaid benefits, effective upon sixty (60) calendar days notice by TENNCARE:

Service	Coverage Provided by TennCare Medicaid
<p>Pharmacy Services (obtained directly from an ambulatory retail pharmacy setting, outpatient hospital pharmacy, mail order</p>	<p>As medically necessary. Certain drugs (known as DESI, LTE, or IRS drugs) are excluded from coverage.</p> <p>TENNCARE is responsible for the provision and payment of pharmacy benefits to individuals who are enrolled in the TennCare Program in the category of TennCare Medicaid/Medicare dual eligible. (However, this does not include pharmaceuticals</p>

<p>pharmacy or those administered to a long-term care facility resident (nursing facility)</p>	<p>administered in a doctor's office.)</p> <p>TENNCARE is not responsible for the provision and payment of pharmacy services for TennCare Medicaid/Medicare dual eligibles prior to the date that TENNCARE has notified the CONTRACTOR through the regular electronic eligibility update that these individuals are eligible in the TennCare/Medicare dual eligible category.</p> <p>Effective July 1, 2003, the aforementioned covered pharmacy services shall be provided by the Pharmacy Benefits Manager (PBM) contracted by the TENNCARE Bureau.</p> <p>Diabetic monitors and supplies as well as home infusion and injectable drugs obtained directly from a pharmacy provider shall be included in the covered pharmacy services that will be provided by the TennCare Pharmacy Benefit Manager effective July 1, 2003.</p> <p>In order to minimize disruption of current service delivery arrangements that may be outside of a CONTRACTOR's PBM arrangement, the CONTRACTOR may continue to reimburse home infusion and injectable drugs through its current arrangement.</p>
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2-3.1.3 TennCare Standard benefits, effective upon sixty (60) calendar days notice by TENNCARE:

Service	Coverage Provided by TennCare Standard
<p>Pharmacy Services (obtained directly from an ambulatory retail pharmacy setting, outpatient hospital pharmacy, mail order pharmacy or those administered to a long-term care facility resident (nursing facility))</p>	<p>As medically necessary. Certain drugs (known as DESI, LTE, or IRS drugs) are excluded from coverage.</p> <p>Effective July 1, 2003, the aforementioned covered pharmacy services shall be provided by the Pharmacy Benefits Manager (PBM) contracted by the TENNCARE Bureau.</p> <p>Diabetic monitors and supplies as well as home infusion and injectable drugs obtained directly from a pharmacy provider shall be included in the covered pharmacy services that will be provided by the TennCare Pharmacy Benefit Manager effective July 1, 2003.</p> <p>In order to minimize disruption of current service delivery arrangements that may be outside of a CONTRACTOR's PBM arrangement, the CONTRACTOR may continue to reimburse home infusion and injectable drugs through its current arrangement.</p>

6. Section 2-3.2 shall be amended by adding a new sentence before the last sentence of the first paragraph so that the amended Section 2-3.2 shall read as follows:

2-3.2 Medical Necessity

The determination of medical necessity shall be made on a case by case basis. The CONTRACTOR shall not employ, and shall not permit others acting on their behalf to employ utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each TennCare enrollee and his/her medical history. The CONTRACTOR shall have the ability to place tentative limits on a service; however, such limits shall be exceeded when medically necessary based on a patient's individual characteristics. The CONTRACTOR shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. The CONTRACTOR may deny services that are non-covered except as otherwise required by EPSDT or unless otherwise directed to provide by TENNCARE and/or an administrative law judge. Any procedures used to determine medical necessity shall be consistent with the following definition:

Services or supplies provided by an institution, physician, or other provider that are required to identify or treat a TennCare enrollee's illness, disease, or injury and which are:

- i. Consistent with the symptoms or diagnosis and treatment of the enrollee's illness, disease, ailment or injury; and
- ii. Appropriate with regard to standards of good medical practice; and
- iii. Not solely for the convenience of an enrollee, physician, institution or other provider; and
- iv. The most appropriate supply or level of services which can safely be provided to the enrollee. When applied to the care of an inpatient, it further means that services for the enrollee's medical symptoms or condition require that the services cannot be safely provided to the enrollee as an outpatient; and
- v. All medically necessary services shall be covered for enrollees under 21 years of age, in accordance with EPSDT requirements, including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989. Effective upon receipt of written notification from TENNCARE, the CONTRACTOR is not required to provide services in accordance with EPSDT requirements to TennCare Standard enrollees under the age of 21.

7. Section 2-3.10 shall be amended by updating the 42 CFR reference so that the amended Section 2-3.10 shall read as follows:

2-3.10 Advance Directives

The CONTRACTOR shall comply with federal requirements concerning advance directives such as a living will or a durable power of attorney for healthcare, as described in 42 CFR 422.128 and 489 Subpart I, and as described in T.C.A. Section 32-11-105, Sections 34-6-201 through 34-6-215, and Sections 68-11-201 through 68-11-224, and as stipulated by the enrollee.

8. Section 2-3.13 shall be amended by adding a new final paragraph to the end of the existing text which shall read as follows:

Effective July 1, 2003, the aforementioned covered pharmacy services shall be provided by the Pharmacy Benefits Manager (PBM) contracted by the TENNCARE Bureau.

9. Sub-items (4)(B), (4)(C), (5)(B), (10) (12), (13) and (27) of Section 2-3.16.8 shall be amended by adding additional language so that the amended sub-items (4)(B), (4)(C), (5)(B), (10) (12), (13) and (27) shall read as follows:

Services Listed in Social Security Act Section 1905(a)	Responsible Entity in Tennessee	Comments
(4)(B) EPSDT services	MCO for physical health services, except as described in Section 2-3.c.2 and 3; BHO for mental health and substance abuse services, except as described in Section 2-3.c.2; Effective October 1, 2002, DBM for dental services except as described in Section 2-3.c.3; Effective July 1, 2003, PBM for Pharmacy Services as described in Section 2-3.a.1	
(4)(C)--Family planning services and supplies	MCO; Effective July 1, 2003, PBM for Pharmacy Services as described in Section 2-3.a.1	
(5)(B)—Medical and surgical services furnished by a dentist.	MCO; Effective October 1, 2002, DBM except as described in Section 2-3.c.3	
(10)—Dental services	MCO; Effective October 1, 2002, DBM except as described in Section 2-3.c.3	
(12)—Prescribed drugs, dentures, and prosthetic devices, and eyeglasses	MCO for physical health services; TennCare PBM for mental	

	<p>health and substance abuse drugs Effective July 1, 2003, PBM for Pharmacy Services as described in Section 2-3.a.1 MCO for dentures until October 1, 2002, DBM for dentures thereafter</p>	
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<p>(13) Other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level</p>	<p>MCO for physical health services; BHO for mental health and substance abuse services Effective October 1, 2002, DBM for dental services as described in Section 2-3.a.1 and 2-3.c.3 Effective July 1, 2003, PBM for Pharmacy Services as described in Section 2-3.a.1</p>	<p>The following are considered practitioners of the healing arts in Tennessee law ¹:</p> <ul style="list-style-type: none"> • Alcohol and drug abuse counselor • Athletic trainer • Audiologist • Certified acupuncturist • Certified master social worker • Certified nurse practitioner • Certified professional counselor • Certified psychological assistant • Chiropractic physician • Chiropractic therapy assistant • Clinical pastoral therapist • Dentist • Dental assistant • Dental hygienist • Dietitian/nutritionist • Dispensing optician • Electrologist • Emergency medical personnel • First responder • Hearing instrument specialist • Laboratory personnel • Licensed clinical perfusionist • Licensed clinical social worker • Licensed practical nurse • Licensed professional counselor • Marital and family therapist, certified • Marital and family therapist, licensed • Massage therapist • Medical doctor • Medical doctor (special training) • Midwives and nurse midwives • Nurse aide
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¹ This list has been provided by the Tennessee Department of Health.

		<ul style="list-style-type: none"> • Occupational therapist • Occupational therapy assistant • Optometrist • Osteopathic physician • Pharmacist • Physical therapist • Physical therapist assistant • Physician assistant • Podiatrist • Psychological examiner • Psychologist • Registered nurse • Registered certified reflexologist • Respiratory care assistant • Respiratory care technician • Respiratory care therapist • Senior psychological examiner • Speech pathologist • Speech pathology aide • X-ray op in chiropractic physician's office • X-ray op in MD office • X-ray op in osteopathic office • X-ray op in podiatrist's office
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(27) Any other medical care, and any other type of remedial care recognized under State law.	MCO for physical health services; BHO for mental health and substance abuse services Effective October 1, 2002, DBM for dental services as described in Section 2-3.a.1 and 2-3.c.3 Effective July 1, 2003, PBM for Pharmacy Services as described in Section 2-3.a.1	See Item (13).
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10. Section 2-3. shall be amended by adding a new Section 2-3.18 which shall read as follows:

2-3.18 Coordination of MCO and PBM Benefits

In order to assure enrollees assigned to TennCare MCOs continue to receive pharmacy services without interruption during the transition and future coordination of their pharmacy benefits, each MCO shall be required to cooperate in any manner necessary, including but not limited to the following:

- (a) The CONTRACTOR and/or its subcontractor (PBM) shall coordinate and interface with TENNCARE and/or the TennCare contracted PBM in order to exchange data in a media

and format acceptable to TENNCARE for the purpose of transitioning necessary information such as authorization requests, refill limits, etc.

- (b) The CONTRACTOR agrees to assure it's providers shall coordinate with the TennCare PBM regarding authorization request for pharmacy services.
- (c) The CONTRACTOR shall be capable of accepting and maintaining data sent from TENNCARE and/or the TennCare PBM regarding enrollee utilization of pharmacy services. The CONTRACTOR shall utilize pharmacy data for management of enrollee health care.
- (d) The CONTRACTOR shall obtain a report from the pharmacy benefits manager (PBM) when provided by the TennCare PBM, that identifies prescribers who have been listed in the top one-hundred (100) prescribers for three (3) weeks out of a four (4) consecutive week period as having prescribed prescription drugs that are not on the Preferred Drug List (PDL). The CONTRACTOR shall use this report as a basis to contact, by telephone one-hundred percent (100%) of its network prescribers (or a provider practicing with the prescribing physician) who wrote prescriptions, within thirty (30) calendar days from the date the report is received,, for the purpose of educating the physician about a prescription drug that is on the PDL that the physician may prescribe as an alternative and to encourage the physician to contact the pharmacy and change the prescription accordingly; any prescriber who cannot be identified through a unique DEA number shall be excluded from this requirement.
- (e) Appeals and member service inquiries related to pharmacy services, provided by the TennCare PBM, shall be the responsibility of TENNCARE and/or the TennCare PBM.

11. Section 2-4.2.f shall be amended by adding a new sentence to the end of the existing text so that the amended Section 2-4.2.f shall read as follows:

- f. Additionally, other vulnerable populations (e.g., persons with special needs such as multiple handicaps, or acute chronic conditions, etc.) may be assigned to a case manager at the MCO level or, at the MCO's discretion, to their attending specialist as their primary care provider. However, the CONTRACTOR shall comply with Section 2-3.j.3(g) regarding enrollees determined to need a course of treatment or regular care monitoring.

12. Section 2-4.3.a shall be amended by deleting and replacing Section 2-4.3.a and adding two new Sections, 2-4.3.l and m so that the amended Sections 2-4.3.a, l and m shall read as follows:

2-4.3.a Performance of reasonable preventive health case management services described in the Quality of Care Monitors, included in this Agreement as Attachment II, as well as mechanisms to assess the quality and appropriateness of care furnished, appropriate referral and scheduling assistance of enrollees with special health care needs , including those identified through the provision of preventive services;

2-4.3.l The CONTRACTOR shall implement mechanisms to assess each TennCare enrollee identified by the State as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals. Enrollees who are dually eligible for TennCare and Medicare are exempt from this requirement.

2-4.3.m The CONTRACTOR shall implement procedures to share, with other MCOs serving the enrollee, the results of its identification and assessment of any enrollee with special health care needs so that those activities need not be duplicated.

13. Section 2-4.4 shall be amended by deleting and replacing Section 2-4.4.b and e in their entirety and by adding new Sections 2-4.4.g and h so that the amended and new sections 2-4.4.b, e, g and h shall read as follows:

2-4.4.b The CONTRACTOR shall allow an enrollee at least one (1) annual preventive care visit to a network obstetrician/gynecologist without obtaining a referral from a case manager or a primary care provider. Effective August 13, 2003, the CONTRACTOR shall allow female enrollees direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a woman's health specialist.

2-4.4.e The CONTRACTOR shall provide all PCPs and Case Managers with a current listing of referral providers. The CONTRACTOR shall supply this listing to all PCPs and Case Managers within thirty (30) days of the effective date of this Agreement. A supplemental listing indicating additions and deletions shall be provided on a quarterly basis thereafter. Quarterly basis for purposes of mailing the supplemental listings shall be based on a calendar year schedule (e.g., Jan. – March, etc.). A copy of the listing, a data file in a media and format described by TENNCARE and documentation from the MCO's mail room or outside vendor indicating the quantity and date mailed shall be sent to TennCare as proof of compliance by the 30th of the month following each quarter in accordance with the reporting schedules as described in Section 6-8 of this Agreement.

2-4.4.g Effective August 13, 2003, the CONTRACTOR must provide for a second opinion from a qualified health care professional within the network, or arrange for the ability of the enrollee to obtain one outside the network, at no cost to the enrollee.

2-4.4.h Effective August 13, 2003, the enrollees determined to need a course of treatment or regular care monitoring, the entity must have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs.

14. Section 2-4.5 shall be amended by adding a new third sentence between the existing second and third sentence so that the amended Section 2-4.5 shall read as follows:

2-4.5 Abusive Utilizers of Pharmacy Services

The CONTRACTOR shall send information to TENNCARE and TennCare Program Integrity regarding lock-in candidates. Enrollees who disagree with such restrictions may appeal to TENNCARE such restrictions pursuant to the medically necessary provisions of the TennCare hearing rules.

15. Section 2-4.6.1.b shall be amended by adding a phrase in the middle of the first sentence so that the amended Section 2-4.6.1.b shall read as follows:

b. PCP Termination. If a PCP ceases participation, the CONTRACTOR shall immediately provide written notice, which shall be considered to be no less than thirty (30) days prior to the effective

date of the termination and no more than fifteen (15) days after receipt or issuance of the termination notice, to each enrollee who has chosen the provider as their PCP. Each notice shall include all components identified in the notice template provided by TennCare. The requirement to provide notice thirty (30) days prior to the effective date of termination shall be waived in instances where a provider becomes physically unable to care for members due to illness, a provider dies, the provider fails to provide thirty (30) days advance notice to the CONTRACTOR, the provider moves from the service area and fails to notify the CONTRACTOR or when a provider fails credentialing, and instead shall be made immediately upon the CONTRACTOR becoming aware of the circumstances.

16. Section 2-4.7.1 shall be deleted in its entirety and replaced by a new Section 2-4.7.1 which shall read as follows:

2.4.7.1 Emergency Medical Services obtained from Out of Plan Providers

The CONTRACTOR's plan shall include provisions governing utilization of and payment by the CONTRACTOR for emergency medical services received by an enrollee from non-contract providers, regardless of whether such emergency services are rendered within or outside the community service area covered by the plan. Coverage of emergency medical services shall not be subject to prior authorization by the CONTRACTOR and shall be consistent with federal requirements regarding post-stabilization services, including but not limited to, 42 CFR Section 438.114(c)(1)(ii)(A). Utilization of and payments to non-contract providers may, at the CONTRACTOR's option, be limited to the treatment of emergency medical conditions, including post-stabilization care that includes medically necessary services rendered to the enrollee until such time as he/she can be safely transported to an appropriate contract service location. Payment amounts shall be consistent with the pricing policies developed by the CONTRACTOR and in accordance with TENNCARE requirements, including TENNCARE rules and regulations for emergency out-of-plan services. Payment by the CONTRACTOR for properly documented claims for emergency medical services rendered by a non-contract provider shall be made within thirty (30) calendar days of receipt of a clean claim by the CONTRACTOR.

The CONTRACTOR must review and approve or disapprove claims for emergency medical services based on the definition of emergency medical services specified in Section 1-3 of this Agreement. If the CONTRACTOR determines that a claim requesting payment of emergency medical services does not meet the definition as specified in Section 1-3 and subsequently denies the claim, the CONTRACTOR shall notify the provider of the denial. This notification shall include information to the provider regarding the CONTRACTOR's process and timeframes for reconsideration and subsequent steps regarding an informal review by TENNCARE. In the event a provider disagrees with the CONTRACTOR's decision to disapprove a claim for emergency medical services, the provider may request an informal review by TENNCARE after having exhausted all steps in the CONTRACTOR's plan for the resolution of such disputes. Said request for an informal review by TENNCARE shall be made within 180 days from the date of service with the exception of instances of retroactive eligibility or circumstances beyond a provider's control such as the involvement of a third party payer. As the result of the informal review, if TENNCARE determines the claim should be allowed, the CONTRACTOR shall make payment for the claim. After informal review, if TENNCARE determines the CONTRACTOR's denial was correct, the provider shall have the right to request a formal hearing, pursuant to T.C.A. Section 71-5-113, on the matter within fifteen (15) calendar days of the decision. All requests for a formal hearing from providers for emergency medical service claims denied by the CONTRACTOR must be submitted in writing to TENNCARE for review and final determination. TENNCARE's decision in such matters shall not be rendered arbitrarily but shall be based upon the facts at hand and the

applicability of the various requirements of this Agreement. The CONTRACTOR agrees to pay previously denied emergency medical service claims if the decision by TENNCARE is to honor the claim.

17. The fifth paragraph of Section 2-4.11 shall be amended by adding references to "1200-13-13-.08, 1200-13-14-.08" so that the amended fifth paragraph of Section 2-4.11 shall read as follows:

Providers or collection agencies acting on the provider's behalf may not bill enrollees for amounts other than applicable cost sharing responsibilities for TennCare covered services except as permitted by TennCare rule 1200-13-12-.08, 1200-13-13-.08, 1200-13-14-.08 and as described below. Providers may seek payment from an enrollee in the following situations:

18. Section 2-4 shall be amended by adding a new Section 2-4.12 which shall read as follows:

2-4.12 Notice of Action to Enrollees

The CONTRACTOR shall comply with all enrollee notice requirements described in TennCare Rules 1200-13-13-.11 and 1200-13-14-.11.

19. Section 2-6.2.c.1(e) shall be amended by adding a new sentence to the end of the existing text so that the amended Section 2-6.2.c.1(e) shall read as follows:

2-6.2.c.1.(e) Shall include a description of cost share responsibilities for enrollees including an explanation that providers and/or the MCO may utilize whatever legal actions that are available to collect these amounts. Further, the information shall indicate that the enrollee may not be billed for covered services except for the amounts of the specified cost share responsibilities and of their right to appeal in the event that they are billed;

20. Section 2-6.2.c.1.(h) shall be deleted and replaced in its entirety so that the new Section 2-6.2.c.1.(h) shall read as follows:

2-6.2.c.1.(h) Shall include an explanation of emergency services and procedures on how to obtain emergency services both in and out of the CONTRACTOR's service area, including but not limited to: an explanation of post stabilization, the use of 911, locations of emergency settings and locations for post-stabilization services;

21. Section 2-6.2.c.1 (m) shall be amended by updating the 42 CFR reference so that the amended Section 2-6.2.c.1 (m) shall read as follows:

2-6.2.c.1(m) Shall include written information concerning advance directives as described in the Code of Federal Regulations, 42 CFR 489 Subpart I and in accordance with 42 CFR 422.128;

22. Section 2-6.2.c.1 shall be amended by adding a new Section 2-6.2.c.1 (v) which shall read as follows:

2-6.2.c.1(v) Shall include directions in order to obtain information that shall be made available upon request regarding the "structure and operation of the MCO" and "physician incentive plans".

23. Section 2-6.4 shall be amended by adding a new sentence to the end of Section 2-6.4.1 and adding a new Section 2-6.4.7 so that the amended Section 2-6.4 shall read as follows:

2-6.4. Prohibited Marketing and/or Communication Activities

The following information and activities are prohibited:

- 2-6.4. 1. Materials and/or activities that mislead, confuse or defraud or that are unfair or deceptive practices or that otherwise violate federal or state consumer protection laws or regulations. This includes materials which mislead or falsely describe covered or available services, membership or availability of network providers, and qualifications and skills of network providers. Further the CONTRACTOR shall adhere to requirements for the written materials to assure that material is accurate and does not mislead, confuse or defraud the recipients or the state agency and materials shall be subject to review by the Medical Care Advisory Committee (MCAC);
 - 2-6.4. 2. Overly aggressive solicitation, such as repeated telephoning or continued recruitment after an offer for enrollment is declined by an enrollee, or similar techniques;
 - 2-6.4. 3. Gifts and offers of material or financial gain as incentives to enroll;
 - 2-6.4. 4. Compensation arrangements with marketing personnel that utilize any type of payment structure in which compensation is tied to the number of persons enrolled;
 - 2-6.4. 5. Direct solicitation of prospective enrollees;
 - 2-6.4. 6. In accordance with federal requirements, independent marketing agents shall not be used in connection with marketing activities. Independent marketing agents shall not mean staff necessary to develop or produce marketing materials or advertising or other similar functions;
 - 2-6.4. 7. In accordance with federal requirements, the CONTRACTOR shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance.
24. Section 2-7.1 shall be amended by adding new language to the end of Sections 2-7.1.d and 2-7.1.f.1, and by adding two new Sections 2-7.1.f.4 and 2-7.1.g so that the amended Section 2-7.1 shall read as follows:

2.7.1 Utilization Management

The CONTRACTOR shall not place arbitrary maximum limits on the length of stay for enrollees requiring hospitalization and/or surgery. The CONTRACTOR shall not employ, and shall not permit others acting on their behalf to employ utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each TennCare enrollee and his/her medical history. Individual patient characteristics must be considered in the determination of readiness for discharge. This requirement is not intended to limit the ability of the CONTRACTOR to place "tentative" limits on the length of a prior authorization or pre-certification.

- a. Inpatient Care. The Contractor shall provide for methods of assuring the appropriateness of inpatient care. Such methodologies shall be based on individualized determinations of medical necessity and, at a minimum, shall include:
 - i. pre-admission certification upon notification for all non-emergency admissions;

- ii. a concurrent review program to monitor and review continued inpatient hospitalization (for hospitals that are not reimbursed on a DRG basis), length of stay (for hospitals that are not reimbursed on a DRG basis), outpatient care, or diagnostic ancillary services regarding their appropriateness and medical necessity. In addition, the Contractor shall have a process in place to determine for emergency admissions, based upon medical criteria, if and when a patient can be transferred to a network facility, if presently in a non-network facility. On-site concurrent hospitalization review should occur in 95% of the cases where applicable at the two most frequently utilized hospitals;
 - iii. admission review for urgent and/or emergency admissions, on a retroactive basis when necessary, in order to determine if the admission is medically necessary, and if the requested length of stay for the admission (for hospitals that are not reimbursed on a DRG basis and for outlier DRG cases) is reasonable based upon an individualized determination of medical necessity. Such reviews shall not result in delays in the provision of medically necessary urgent or emergency care;
 - iv. Pre-admission certification should not be employed for admissions for the normal delivery of children;
 - v. Prospective review procedures may also include pre-admission testing criteria and criteria for same day surgery procedures. If inpatient hospital pre-admission certification is utilized authorization or denial must occur within one business day of the request.
- b. Case Management. The Contractor shall maintain a case management program for enrollees. Enrollee participation is voluntary. The CONTRACTOR must utilize procedures and criteria that identify unique or complex cases that will benefit from intensive medical case management.
- c. Discharge Planning. The Contractor shall maintain and operate a formalized discharge planning program. The CONTRACTOR may delegate responsibility for discharge planning in accordance with requirements for the delegation of responsibilities specified in Attachment II.
- d. Disease Management. The Contractor must have in place or develop and implement a disease management and health promotion and prevention program. The Contractor shall develop and implement one disease management program for a high cost, high prevalence disease, designed to optimize the health status of members. The program shall include a statistically valid methodology designed to measure the impact on health status of participating members, and the Contractor shall provide the State with the results of the analysis of the program's impact at least 14 months after implementation. The State reserves the right to review and comment on the programs. In the event the TennCare Bureau contracts with an outside entity for the administration of any Disease Management Program, TENNCARE shall be responsible for the administrative cost of the outside contractual arrangement for the Disease Management Program. However, the CONTRACTOR shall cooperate and participate to the extent practical and feasible with any disease management program as developed and/or described by TENNCARE.

- e. Hospitalizations and Surgeries. The CONTRACTOR must comply with any applicable laws or rules related to length of hospital stay. TENNCARE will closely monitor encounter data related to length of stay and re-admissions to identify potential problems. If indicated, TENNCARE or the EQRO may conduct special studies to assess the appropriateness of hospital discharges.
- f. Prior Authorization
1. General Rule. If prior authorization of a service is granted by the CONTRACTOR, subcontractor or an agent, payment for the pre-approved service shall not be denied based on the lack of medical necessity, assuming that the enrollee is eligible on the date of service, unless it is determined that the facts at the time of the denial of payment are significantly different than the circumstances which were described at the time that prior authorization was granted. Prior Authorization shall not be required for emergency services. Prior authorization requests shall be reviewed subject to the guidelines described in TennCare Rules 1200-13-13 and 1200-13-14 which include, but are not limited to, provisions regarding decisions, notices, medical contraindication, and the failure of an MCO to act timely upon a request.
 2. At time of Enrollment. In the event an enrollee entering the MCO's plan is receiving medically necessary TennCare covered services the day before enrollment, the CONTRACTOR shall continue to make payment, without any form of prior approval and without regard to whether such services are being provided within or outside the CONTRACTOR's provider network until such time as the CONTRACTOR can reasonably transfer the enrollee to a service and/or network provider without impeding service delivery that might be harmful to the enrollee's health. If it is medically necessary that care extend beyond thirty (30) days, the CONTRACTOR shall require prior authorization for continuation of the services beyond thirty (30) days. Care rendered to an enrollee in the Contractor's plan beyond thirty (30) days that is out-of-plan or out-of-network for which a provider has not sought prior authorization shall not be reimbursed.
 3. Prenatal Care. In the event an enrollee entering the CONTRACTOR's plan is receiving medically necessary prenatal care services the day before enrollment, the CONTRACTOR shall continue to make payment for such medically necessary services, without any form of prior approval and without regard to whether such services are being provided within or outside the CONTRACTOR's provider network until such time as the CONTRACTOR can reasonably transfer the enrollee to a service and/or network provider without impeding service delivery that might be harmful to the enrollee's health. The CONTRACTOR shall require, as a condition of payment, that the service provider accept the amount paid by the CONTRACTOR or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payor) plus any applicable amount of cost sharing responsibilities due from the enrollee as payment in full for the service.
 4. Notice Requirements. Notice of adverse actions regarding prior authorization requests shall be provided within the following guidelines:

- (a) Provider Notice. The CONTRACTOR must notify the requesting provider of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider need not be in writing; however, the CONTRACTOR must be able to produce proof or documentation of notice to the requesting provider.
- (b) Enrollee Notice. See notice provisions in TennCare Rule 1200-13-13-.11 and 1200-13-14-.11.

g. Compensation for Utilization Management Activities. CONTRACTOR shall assure, consistent with 42 CFR 438.6(h), and 42 CFR 422.208, that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee, as provided by the Balanced Budget Act of 1997 and the provisions of 42 CFR 438.210(e).

25. The second paragraph of Section 2-8 shall be amended by adding a new third sentence and the references "1200-13-13-.11" and "1200-13-14-.11" so that the amended first paragraph of Section 2-8 shall read as follows:

The enrollees shall have the right to file appeals regarding adverse actions taken by the CONTRACTOR. For purposes of this requirement, appeal shall mean an enrollee's right to contest verbally or in writing, any adverse action taken by the CONTRACTOR to deny, reduce, terminate, delay or suspend a covered service as well as any other acts or omissions of the CONTRACTOR which impair the quality, timeliness, or availability of such benefits. An appeal may be filed by the enrollee or by a person authorized by the enrollee to do so, including but not limited to, a provider with the enrollee's written consent. The CONTRACTOR shall provide readable materials reviewed and approved by TENNCARE, informing enrollees of their appeal rights. The CONTRACTOR has internal appeal procedures for both TennCare Medicaid enrollees as well as TennCare Standard enrollees in accordance with TennCare rules 1200-13-12-.11, 1200-13-13-.11, 1200-13-14-.11 or any applicable TennCare rules, subsequent amendments, TennCare Waiver or subsequent Court Orders governing the appeals process.

26. Section 2-8.a.9 shall be deleted in its entirety.
27. Section 2-8.a. shall be amended by adding new Sections 2-8.a.9 and 10 and renumbering the existing Section 2-8.a.10 as 2-8.a.11 so that the new Sections 2-8.a.9 and 10 shall read as follows:

2-8.a.9. The Contractor shall require providers to display notices of enrollee's right to appeal adverse actions affecting services in public areas of each facility in accordance with TennCare rules. Contractor shall ensure that providers have correct and adequate supply of public notices.

2-8.a.10. Except for initial reconsideration by an MCO, as permitted under the TennCare rules, no person who is an employee, agent or representative of an MCO may participate in deciding the outcome of a TennCare appeal. No state official may participate in deciding the outcome of a beneficiary's appeal who was directly involved in the initial determination of the action in question. The State will ensure that decision makers on grievances and appeals were not involved in previous levels of review or decision-making and who are health care professionals with clinical expertise in treating the enrollee's condition or disease if any of the following apply:

- a denial appeal based on lack of medical necessity.
- a grievance regarding denial of expedited resolutions of an appeal.
- any grievance or appeal involving clinical issues.

The Contractor shall keep a record of who reviews each reconsideration. The State will monitor compliance with this provision.

28. Section 2-9.1 shall be amended by adding a new Item d. which shall read as follows:

- d. Data that must be Certified. When State payments to an MCO are based on data submitted by the MCO, the State must require certification of the data as provided in 42 CFR 438.606. The data that must be certified include, but are not limited to, enrollment information, encounter data, and other information required by the State and contained in contracts, proposals and related documents. The data must be certified by one of the following: the MCO's Chief Executive Officer, The MCO's Chief Financial Officer, or An individual who has delegated authority to sign for, and who reports directly to the MCO's Chief Executive Officer or Chief Financial Officer. The certification must attest, based on best knowledge, information, and belief, as follows:
1. To the accuracy, completeness and truthfulness of the data..
 2. To the accuracy, completeness and truthfulness of the documents specified by the State.
 3. The MCO must submit the certification concurrently with the certified data.

29. Section 2-9.2.a shall be deleted and replaced in its entirety so that the amended Section 2-9.2.a shall read as follows:

- a. The CONTRACTOR may not knowingly have a director, officer, partner, or person with beneficial ownership of more than 5% of the entity's equity who has been debarred or suspended by any federal agency. The CONTRACTOR shall not have an employment, consulting, or any other agreement with a person that has been debarred or suspended by any federal agency for the provision of items or services that are significant and material to the entity's contractual obligation with the State. To the best of its knowledge and belief, the CONTRACTOR certifies by its signature to this Agreement that the CONTRACTOR and its principals:
1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal or State department or Contractor;
 2. have not within a three (3) year period preceding this Agreement been convicted of, or had a civil judgment rendered against them from commission of fraud, or a criminal offence in connection with obtaining attempting to obtain, or performing a public (federal, State, or Local) transaction or grant under a public transaction; violation of federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property;
 3. are not presently indicted for or otherwise criminally or civilly charged by a government entity (federal, State, or Local) with commission of any of the offenses detailed in section b. of this certification; and

4. have not within a three (3) year period preceding this Agreement had one or more public transactions (federal, State, or Local) terminated for cause or default.

30. Section 2-9.4 shall be amended by adding new introductory text so that the amended Section 2-9.4 shall read as follows:

2-9.4 Network Management

The CONTRACTOR shall provide or assure the provision of all covered services specified in Section 2-3.1 of this Agreement. The CONTRACTOR may provide these services directly or may enter into agreements with providers and provider subcontracting entities or organizations who will provide services to the enrollees in exchange for payment by the CONTRACTOR for services rendered.

1. Should the CONTRACTOR elect to contract with providers for the provision of covered services, the CONTRACTOR shall adhere to the following:
 - (a) The CONTRACTOR shall not execute provider agreements with providers who have been excluded from participation in the Medicare and/or Medicaid programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with the TENNCARE program.
 - (b) No later than August 1, 2003, the CONTRACTOR shall have in place, written policies and procedures for the selection and/or retention of providers and policies and procedures must not discriminate against particular providers that service high risk populations or specialize in conditions that require costly treatment.
 - (c) The CONTRACTOR shall not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. The CONTRACTOR's ability to credential providers as well as maintain a separate network and not include any willing provider is not considered discrimination.
 - (d) If the CONTRACTOR declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.
 - (e) The CONTRACTOR shall maintain all provider agreements in accordance with the provisions specified in Title 42, CFR §438.12, 438.214 and Section 2-18 of this Agreement.
 - (f) The CONTRACTOR shall make provider payments in accordance with Section 5 of this Contract and shall negotiate changes in reimbursement rates as required by TENNCARE.
2. Section 2-9.4.1 shall not be construed to:

- (a) Require the CONTRACTOR to contract with providers beyond the number necessary to meet the needs of its enrollees;
 - (b) Preclude the CONTRACTOR from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or
 - (c) Preclude the CONTRACTOR from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to enrollees.
3. The CONTRACTOR may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient for the following:
- (a) The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self administered;
 - (b) Any information the enrollee needs in order to decide among all relevant treatment options;
 - (c) The risks , benefits, and consequences of treatment or non-treatment; or
 - (d) The enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
4. The CONTRACTOR shall ensure that punitive action is not taken against a provider who either requests an expedited resolution or supports and enrollee's appeal.
5. The CONTRACTOR shall notify and make TENNCARE and TDCI TennCare Division aware of any operations or plans to operate a Physician Incentive Plan (PIP). Prior to implementation of any such plans, CONTRACTOR shall submit to TDCI TennCare Division any provider agreement templates or subcontracts that involve a PIP for review as a material modification. CONTRACTOR shall not implement a PIP in the absence of TDCI TennCare Division review and approval, which review will include review for compliance with applicable state and federal law. If the CONTRACTOR operates a PIP, the CONTRACTOR shall assure that no specific payment be made directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual. If the CONTRACTOR operates a PIP, upon TENNCARE's request, the CONTRACTOR must report descriptive information about its incentive plan in sufficient detail to enable TENNCARE to adequately monitor the CONTRACTOR. The information that may be requested shall include, but not be limited to, the following:
- (a) Whether services not furnished by the physician or physician group are covered by the incentive plan.
 - (b) The type or types of incentive arrangements, such as, withholds, bonus, capitation.
 - (c) The percent of any withhold or bonus the plan uses.

- (d) Assurance that the physicians or physician group has adequate stop-loss protection, and the amount and type of stop-loss protection.
- (e) The patient panel size and, if the plan uses pooling, the pooling method.
- (f) If the CONTRACTOR is required to conduct enrollee surveys, a summary of the survey results.

6. For purposes of network management, the CONTRACTOR shall, at a minimum, adhere to and/or provide for the following:

- a. The CONTRACTOR shall notify all network providers to file claims associated with their services directly with the CONTRACTOR, or its subcontractors, on behalf of TennCare Select enrollees.
- b. The CONTRACTOR shall notify all network providers of and enforce compliance with all provisions relating to utilization management procedures.
- c. Provider Profiling. The CONTRACTOR shall profile TennCare Select providers and Best Practice Network Primary Care Providers. Provider profiling will include the following:

- 1. Out-of-Network Utilization. The CONTRACTOR shall maintain a procedure to identify out-of-network utilization of enrollees by PCP panel (including BPN-PCPs), establish criteria for the evaluation of such instances and provide information to the state concerning the procedure, criteria and the results of any reviews and follow-up activities to correct referrals that are found to be "inappropriate" (e.g., consistent utilization of non-network providers when in-network providers available) on a quarterly basis.
- 2. Specialist Referrals. The CONTRACTOR shall maintain a procedure to identify Specialty provider utilization of enrollees by PCP panel (including BPN-PCPs), establish criteria for evaluation for specialty utilization and provide information to the state concerning the procedure, criteria and the results of any reviews and follow-up activities to correct specialist utilization found to be inappropriate on a quarterly basis.
- 3. Emergency Room Utilization. The CONTRACTOR shall maintain a procedure to identify enrollees who establish a pattern of accessing emergency room services, establish criteria for the evaluation of such instances, and notify the enrollee's PCP (including BPN-PCPs). The CONTRACTOR shall provide information to the state concerning the procedure, criteria and results of any reviews and follow-up activities on a quarterly basis.

31. Section 2-9.7.j shall be deleted in its entirety and the remaining Sections of 2-9.7 shall be renumbered and any references thereto shall be amended accordingly.

32. Section 2-9.9 shall be deleted and replaced in its entirety so that the amended Section 2-9.9 shall read as follows:

2-9.9 Fraud and Abuse Prevention and Detection

Pursuant to Executive Order 47 and 42 CFR § 1007, the Tennessee Bureau of Investigation Medicaid Fraud Control Unit (TBI MFCU) is the state agency responsible for the investigation of provider fraud and abuse in the State Medicaid program (TennCare).

The TennCare Program Integrity Unit is responsible for assisting TBI MFCU with provider cases and has the primary responsibility to investigate TennCare enrollee fraud and abuse.

The Contractor shall immediately report to the TBI MFCU any known or suspected fraud and/or abuse, including, but not limited to, the false or fraudulent filings of claims and/or the acceptance or failure to return monies allowed or paid on claims known to be false or fraudulent. The Contractor shall not investigate or resolve the suspicion, knowledge or action without informing the TBI MFCU, and shall cooperate fully in any investigation by the TBI MFCU or subsequent legal action that may result from such an investigation. The Contractor and health care providers, whether participating or non-participating providers, shall, upon request and as required by this CRA or state and/or federal law, make available to the TBI MFCU any and all administrative, financial and medical records relating to the delivery of items or services for which TennCare monies are expended. In addition, the TBI MFCU shall, as required by this CRA or state and/or federal law, be allowed access to the place of business and to all TennCare records of any Contractor or health care provider, whether participating or non-participating, during normal business hours, except under special circumstances when after hour admission shall be allowed. Special circumstances shall be determined by the TBI MFCU.

The Contractor shall include in any of its provider agreements a provision requiring, as a condition of receiving any amount of TennCare payment, the provider must comply with Section 1-5 of this CRA.

The Contractor shall report TennCare enrollee fraud and abuse to the TennCare Program Integrity Unit. The Contractor may be asked to help and assist in investigations by providing requested information and access to records. The Contractor and health care providers, whether participating or non-participating providers, shall, upon request and as required by this CRA or state and/or federal law, make available any and all supporting documentation/records relating to delivery of items or services for which TennCare monies are expended. Shall the need arise, the TennCare Program Integrity Unit shall be allowed access to the place of business and to all TennCare records of any TennCare Contractor or health care provider, whether participating or non-participating, during normal business hours, as required by this CRA or state and/or federal law.

Nothing herein shall require the CONTRACTOR to assure non-participating providers are compliant with TENNCARE contracts or state and/or federal law.

- a. The CONTRACTOR shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities. The CONTRACTOR shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the CONTRACTOR in preventing and detecting potential fraud and abuse activities.

b. The CONTRACTOR shall have a written Fraud and Abuse compliance plan. A paper and electronic copy of the plan shall be provided to the TennCare Program Integrity Unit. The CONTRACTOR's specific internal controls and policies and procedures shall be described in a comprehensive written plan and be maintained on file with the CONTRACTOR for review and approval by the TennCare Program Integrity Unit within ninety (90) days of the effective date of this Agreement. The TennCare Program Integrity Unit shall provide notice of approval, denial, or modification to the CONTRACTOR within thirty (30) days of review. The CONTRACTOR shall make any requested updates or modifications available for review to TENNCARE and/or the TennCare Program Integrity Unit as requested by TENNCARE and/or the TennCare Program Integrity Unit within thirty (30) days of a request. The State shall not transfer their law enforcement functions to the CONTRACTOR. At a minimum the written plan shall:

1. Ensure that all officers, directors, managers and employees know and understand the provisions of the CONTRACTOR's fraud and abuse compliance plan;
2. Contain procedures designed to prevent and detect potential or suspected abuse and fraud in the administration and delivery of services under this contract;
3. Include a description of the specific controls in place for prevention and detection of potential or suspected abuse and fraud, such as:
 - a. Claims edits;
 - b. Post-processing review of claims;
 - c. Provider profiling and credentialing;
 - d. Prior authorization;
 - e. Utilization management;
 - f. Relevant subcontractor and provider agreement provisions;
 - g. Written provider and enrollee material regarding fraud and abuse referrals.
4. Contain provisions for the confidential reporting of plan violations to the designated person as described in item 3 below;
5. Contain provisions for the investigation and follow-up of any compliance plan reports;
6. Ensure that the identities of individuals reporting violations of the plan are protected;
7. Contain specific and detailed internal procedures for officers, directors, managers and employees for detecting, reporting, and investigating fraud and abuse compliance plan violations;
8. Require any confirmed or suspected provider fraud and abuse under state or federal law be reported to TBI MFCU and that enrollee fraud and abuse be reported to the TennCare Program Integrity Unit;

9. Ensure that no individual who reports plan violations or suspected fraud and abuse is retaliated against.
 - c. The CONTRACTOR shall comply with the applicable requirements of the Model Compliance Plan for HMOs when the final model plan is issued by the U.S. Department of Health and Human Services, the Office of Inspector General (OIG).
 - d. The CONTRACTOR shall designate an officer or director in its organization who has the responsibility and authority for carrying out the provisions of the fraud and abuse compliance plan.
 - e. The CONTRACTOR shall submit an annual report to the TennCare Program Integrity Unit that includes summary results of fraud and abuse tests performed as required by 1-5.b.1.iii. and detailed in the CONTRACTOR's Fraud and Abuse compliance plan. The report should cover results for the year ending June 30 and be submitted by September 30 each year. This information in this report shall be provided in accordance with and in a format as described in the CONTRACTOR's approved compliance plan.
33. Section 2-10.6 shall be deleted in its entirety and all subsequent sections shall be renumbered as well as all references thereto.
34. The renumbered Section 2-10.8 shall be deleted and replaced in its entirety so that the amended Section 2-10.8 shall read as follows:

2-10.8 Financial Reporting

The CONTRACTOR shall file with the Tennessee Department of Commerce and Insurance, TennCare Division, a report on the form prescribed by the National Association of Insurance Commissioners for health maintenance organizations, on or before March 1 of each calendar year, which report is currently required to be filed by all licensed health maintenance organizations pursuant to Tennessee Code Annotated 56-32-208. This annual report shall also contain a supplemental income statement for TennCare Select detailing the CONTRACTOR's fourth quarter and year-to-date revenues earned and expenses paid as a result of the CONTRACTOR's administration of TennCare Select. The CONTRACTOR in preparing this annual report shall comply with any and all rules and regulations of the Tennessee Department of Commerce and Insurance related to the preparation and filing of this report.

The CONTRACTOR shall file with the Department of Commerce and Insurance, TennCare Division, a quarterly financial report on the form prescribed by the National Association of Insurance Commissioners for health maintenance organizations. These quarterly reports shall be filed on or before June 1 (covering first quarter of current year), September 1 (covering second quarter of current year) and December 1 (covering third quarter of current year) of each calendar year. Each quarterly report shall also contain a supplemental income statement detailing the CONTRACTOR's quarterly and year-to-date revenues earned and expenses paid as a result of the CONTRACTOR's administration of TennCare Select.

The CONTRACTOR shall also cause an audit of its business transactions to be performed by a licensed certified public accountant, including but not limited to the financial transactions made under this Agreement. Such audit shall be performed in accordance with the National Association of Insurance Commissioners Annual Statement Instructions regarding the

Annual Audited Financial Report. There are 3 exceptions to the aforementioned statement instructions:

1. The CONTRACTOR shall submit to the Tennessee Department of Commerce and Insurance, TennCare Division, the audited financial statements covering the previous calendar year by May 1 of each calendar year.
2. Any requests for extension of the May 1 submission date must be granted by the Comptroller of the Treasury pursuant to the "Contract to Audit Accounts."
3. The audit report shall include an income statement addressing the TennCare operations of the CONTRACTOR.
4. A breakdown of actual administrative expenses into the following components: Subcontractor Costs, Member Services, Network Development and Management, Claims Processing, Utilization Management, Quality Assurance, Marketing, and Other Costs.

The agreement for such audits shall be subject to prior approval of the Comptroller of the Treasury and must be submitted on the standard "Contract to Audit Accounts". In the event that terms included in the standard contract to audit accounts differ from those contained in the TennCare Agreement, the TennCare Agreement takes precedent. These financial reporting requirements shall supersede any other reporting requirements required of the CONTRACTOR by the Tennessee Department of Commerce and Insurance, and the Tennessee Department of Commerce and Insurance shall enact any necessary rule or regulation to conform to this provision of the Agreement.

35. The renumbered Section 2-10.10.1 shall be amended by adding new text to the end of the initial paragraph so that the amended Section 2-10.10.1 shall read as follows:

2-10.10.1 Prescription Drug Summary

The CONTRACTOR shall provide a listing of the top 25 prescription drug therapeutic classes by amount paid on a quarterly basis. These reports shall include the following data elements (does not apply to dual eligibles) Effective July 1, 2003, pharmacy services shall be covered by a TennCare contracted pharmacy benefits manager (PBM). However, these reports shall be required to continue until such time as all claims processed are reported by the CONTRACTOR or its subcontracted pharmacy benefits manager (PBM):

1. Rank
2. Therapeutic Class Name
3. Quantity Dispensed (e.g., 1 tube, 100 pills, 1000 ml., etc.)
4. Number of Prescriptions Filled
5. Dispensing Fee
6. Ingredient Cost
7. Total Amount Paid for Each Therapeutic Class
8. Amount Paid as a Percentage of Total Drug Payments

36. The renumbered Section 2-10.10.8 shall be deleted and replaced in its entirety so that the amended Section 2-10.10.8 shall read as follows:

2-10.10.8 Cost and Utilization Reports

- a. The CONTRACTOR shall report Cost and Utilization information for: Groups 1.A and 1.B; Group 2; and for all other Groups by TennCare enrollee eligibility category as described in Attachment XII, Exhibits L.1 through L.5. CONTRACTOR shall submit a written explanation for how service data will be mapped to the categories identified in said Exhibits within thirty (30) days of the execution date of this Amendment. These reports shall be maintained in an Excel spreadsheet format and shall be sent via e-mail to TENNCARE on a quarterly basis and shall be due to TENNCARE seventy-five (75) calendar days following the quarter for which the CONTRACTOR is reporting.
- b. In order to support federal reporting requirements, the CONTRACTOR shall provide the Cost and Utilization information specified in Attachment XII, Exhibits L.1 through L.5, separately for individuals who are dually eligible for Medicaid and Medicare in response to an adhoc request from TennCare in accordance with the timeframes specified in Section 6-8.

37. The first sentence of Section 2-12.b shall be deleted and replaced in its entirety so that the amended Section 2-12.b shall read as follows:

2-12.b. The CONTRACTOR and its subcontractors shall make all records (including but not limited to, financial and medical records) available at the CONTRACTOR's and/or the subcontractor's expense for review, audit, or evaluation by authorized federal, state, and Comptroller of Treasury personnel. Access will be during normal business hours and will be either through on-site review of records or through the mail. All records to be sent by mail will be sent to TENNCARE within twenty (20) working days of request unless otherwise specified by TENNCARE or TennCare rules and regulations. Requested records shall be provided at no expense to TENNCARE. Records related to appeals shall be forwarded within the time frames specified in the appeal process portion of this Agreement. Such requests made by TENNCARE shall not be unreasonable.

38. Section 2-17 shall be amended by adding new Sections 2-17.a. and renumbering the existing Sections 2-17. a – j accordingly so that the amended Section 2-17.a shall read as follows:

- a. Subcontract Relationships and Delegation. If the CONTRACTOR delegates responsibilities to a subcontractor, the CONTRACTOR shall assure that the subcontracting relationship and subcontracting document(s) comply with the requirements of the Balanced Budget Act of 1997, including, but not limited to, compliance with the applicable provisions of 42 CFR 438.230(b) and 42 CFR 434.6 as described below:
 1. The CONTRACTOR shall evaluate the prospective subcontractor's ability to perform the activities to be delegated.
 2. The CONTRACTOR shall require that the agreement be in writing and specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

3. The CONTRACTOR shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review consistent with industry standards or State MCO laws and regulations.
 4. The CONTRACTOR shall identify deficiencies or areas for improvement and the CONTRACTOR and the subcontractor shall take corrective action as necessary.
39. Section 2-17 shall be amended by deleting and replacing the **renumbered** Section 2-17.h so that the new Sections 2-17. h shall read as follows:
- h. Claims Processing. All claims for services furnished to a TennCare enrollee filed with a CONTRACTOR must be processed by either the CONTRACTOR or by one (1) subcontractor retained by the organization for the purpose of processing claims. However, another entity can process claims related to pharmacy (effective July 1, 2003 TENNCARE shall contract directly with a PBM for the provision of pharmacy services as described in Section 2-3.a.1), vision, lab or transportation if that entity has been retained by the CONTRACTOR to arrange and provide for the delivery of said services.
40. Section 2-17 shall be amended by deleting and replacing the **renumbered** Section 2-17.j so that the new Sections 2-17. j shall read as follows:
- j. Notice of Subcontractor Termination. When a subcontract that relates to the provision of services to enrollees or claims processing services is being terminated between the CONTRACTOR and a subcontractor, the CONTRACTOR shall give at least thirty (30) days prior written notice of the termination to TENNCARE and the TennCare Division, TDCI. Such notice shall include, at a minimum, a CONTRACTOR's intent to change to a new subcontractor for the provision of said services, an effective date for termination and/or change, as well as any other pertinent information that may be needed. In addition to prior written notice, the CONTRACTOR shall also provide TENNCARE with a transition plan upon request. Failure to adhere to guidelines and requirements regarding administrative responsibilities, including subcontract requirements may result in the application of liquidated damages or intermediate sanctions as described in Section 4-8 of this Agreement. TENNCARE reserves the right to require this notice requirement and procedures for other subcontracts if determined necessary upon review of the subcontract for approval. Finally, this subsection does not relieve CONTRACTOR of any responsibilities to submit all proposed material modifications of the MCO operations to TDCI TennCare Division for prior review and approval as required by Title 56, Chapter 32, Part 2.
41. Section 2-17 shall be amended by adding a new Section 2-17. l which shall read as follows:
- l. Compensation for Utilization Management Activities. Should the CONTRACTOR have a subcontract arrangement for utilization management activities, the CONTRACTOR shall assure, consistent with 42 CFR 438.6(h) and 42 CFR 422.208, that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee, as provided by the Balanced Budget Act of 1997 and the provisions of 42 CFR 438.210(e).

42. Section 2-18.ll shall be amended by adding new text to the end of the existing text so that the amended Section 2-18.ll shall read as follows:

2-18. ll. Require that the provider display notices of the enrollee's right to appeal adverse action affecting services in public areas of their facility(s) in accordance with TennCare rules, subsequent amendments, or any and all Court Orders. The CONTRACTOR shall ensure that providers have correct and adequate supply of public notices.;

43. Section 2-18 shall be amended by deleting and replacing Section 2-18.qq and adding a new section 2-18.rr so that the amended and new Sections 2-18.qq and rr shall read as follows:

2-18. qq. All primary care provider agreements shall specify that its network primary care providers shall submit all claims with a primary behavioral health diagnosis (ICD-9 CM 290.xx – 319.xx) to the CONTRACTOR for payment.

2-18. rr. Require that providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.

44. The first paragraph of Section 2-19 shall be amended by adding a new sentence to the end of the existing text so that the amended first paragraph of Section 2-19 shall read as follows:

2-19. Fidelity Bonds – Net Worth

The CONTRACTOR shall secure and maintain during the life of this Agreement any fidelity bonds and/or insolvency protection required by the Tennessee Department of Commerce and Insurance. Proof of coverage must be submitted to TENNCARE as a deliverable item pursuant to Attachment I of this Agreement within sixty (60) calendar days after execution of this Agreement and prior to the delivery of health care, which ever comes first. Bonds shall be required for facility improvement or construction (over \$100,000). However, MCOs under this contract are not bound by this requirement nor will the TennCare program reimburse for facility improvement or construction outside of the administrative fees paid by TENNCARE.

45. Section 2-21 shall be amended by adding a new Section 2-21.e so that the amended Section 2-21 shall read as follows:

2-21. Ownership and Financial Disclosure

The CONTRACTOR shall disclose, to TENNCARE, the Comptroller General or Health Care Financing Administration, full and complete information regarding ownership, financial transactions and persons convicted of criminal activity related to Medicare, Medicaid, or the Federal Title XX programs in accordance with federal and state requirements, including Public Chapter 379 of the Acts of 1999. This disclosure shall be made at times and on forms prescribed by the TENNCARE agency, but no less frequently than on an annual basis to be provided no later than March 1 of each calendar year. The following information shall be disclosed:

- 2-21. a. The name and address of each person with an ownership or control interest in the disclosing entity or in any provider or subcontractor in which the disclosing entity has direct or indirect ownership of five percent (5%) or more and whether any of the persons named pursuant to this

requirement is related to another as spouse, parent, child, or sibling. This disclosure shall include the name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest.

- 2-21. b. The identity of any provider or subcontractor with whom the CONTRACTOR has had business transactions totaling more than twenty-five thousand dollars (\$25,000) during the twelve (12) month period ending on the date of the disclosure and any significant business transactions between the CONTRACTOR, any wholly owned supplier, or between the CONTRACTOR and any provider or subcontractor, during the five (5) year period ending on the date of the disclosure.
- 2-21. c. The identity of any person who has an ownership or control interest in the CONTRACTOR, or is an agent or managing employee of the CONTRACTOR and who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Federal Title XX services program since the inception of those programs.
- 2-21. d. Disclosure from officials in legislative and executive branches of government as to possible conflicts of interest.
- 2-21. e. If the CONTRACTOR is not a federally qualified MCO, the CONTRACTOR shall disclose certain transactions with parties of interest to TENNCARE. Transactions shall be reported according to the following guidelines:
1. The CONTRACTOR shall disclose the following transactions:
 - (a) Any sale, exchange or lease of any property between the HMO and a party in interest;
 - (b) Any lending of money or other extension of credit between the HMO and a party in interest; and
 - (c) Any furnishing for consideration of goods, services (including management services) or facilities between the HMO and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.
 2. The information which must be disclosed in the transactions includes:
 - (a) The name of the party in interest for each transaction;
 - (b) A description of each transaction and the quantity or units involved;
 - (c) The accrued dollar value of each transaction during the fiscal year; and
 - (d) Justification of the reasonableness of each transaction.
 3. If the contract is being renewed or extended, the CONTRACTOR must disclose information on business transactions which occurred during the prior contract period. If the contract is an initial contract with TENNCARE, but the CONTRACTOR has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period must be disclosed. The business transactions which must be reported are not limited to transactions related to serving the Medicaid/TennCare enrollment. All of the CONTRACTOR's business transactions must be reported.
 4. A party in interest is:
 - (a) Any director, officer, partner, or employee responsible for management or administration of an HMO and HIO; any person who is directly or indirectly the beneficial owner of more than 5% of the equity of the HMO; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured

by, and valuing more than 5% of the HMO; or, in the case of an HMO organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;

- (b) Any organization in which a person described in subsection 1 is director, officer or partner; has directly or indirectly a beneficial interest of more than 5% of the equity of the HMO; or has a mortgage, deed of trust, note, or other interest valuing more than 5% of the assets of the HMO;
- (c) Any person directly or indirectly controlling, controlled by, or under common control with a HMO; or
- (d) Any spouse, child, or parent of an individual described in subsections (a), (b), or (c)

TENNCARE and/or the Secretary of Health and Human Services may request information to be in the form of a consolidated financial statement.

- 46. Section 3-1.2.a shall be amended by deleting Item 2 and renumbering the existing items.
- 47. Section 3-1.2.1.a. shall be amended by deleting and replacing Item 1 so that the amended Section 3-1.2.1.a.1 shall read as follows:
 - 1. Provide EPSDT screenings timely if requested by DCS Case Managers.
- 48. Section 3.1.2 shall be amended by deleting Section 3.1.2.2 in its entirety and renumbering the existing Sections 3.1.2.3 and 3.1.2.4 accordingly.
- 49. Section 3-1.3 shall be amended by deleting and replacing parts a and b in their entirety so that the amended Section 3-1.3 shall read as follows:

3-1.3 Safety-Net

- a. EPSDT – Physical Health Screenings. The CONTRACTOR shall include Local Health Departments in their provider network for the provision of EPSDT services.
- b. EPSDT – Dental Screenings. Local Health Departments, in which dental services are available, will provide safety net services. Whenever the dental network is inadequate and dental care is urgent, the Dental Benefits Manager shall arrange for an out-of-network provider to provide the care.

Effective October 1, 2002, the TennCare Dental Benefits Manager shall assume responsibility for the provision and payment of dental benefits. However, CONTRACTOR shall agree to cooperate and participate with any subsequent plan for Children in State custody which has been provided and/or approved by the court.

- 50. Section 3-1.5.b shall be amended by adding a new phrase to the end of the first sentence so that the amended Section 3-1.5.b shall read as follows:
 - b. Monitoring. The CONTRACTOR shall conduct a medical chart review two times over the course of the original eighteen months of this Agreement and once in calendar year 2003 of a statistically valid sample of each BPN provider's medical charts to document Best Practice Network provider compliance with the requirements of the plan for children in state custody and any subsequent plan related to the provision of services to children in State custody of which the

provider received advance notice, including the use of Best Practice Guidelines and completion of all seven required components of initial EPSDT exams (or documentation explaining any reasons for not adhering to the guidelines or completing the seven components of the exam) for those cases where the BPN provider conducted the EPSDT exam. The sampling methodology employed must be approved by TennCare prior to use.

51. Section 3-1.7 shall be amended by deleting part a. in its entirety, renumbering the existing parts and deleting and replacing the second sentence of the new part a. so that the amended Section 3-1.7 shall read as follows:

3-1.7 Service Delivery Requirements

In addition to satisfying the requirements of Section 2 of this Agreement for the delivery of services, the CONTRACTOR shall meet the following requirements for the delivery of services to children in state custody:

- a. Failure to Maintain Adequate Capacity in Network and Recruitment of Best Practice Network Providers. The CONTRACTOR shall recruit Best Practice Network providers who have appropriate credentials, are willing to follow BPN guidelines and are willing to participate in its network. DCS will report any incidences where providers are not available to deliver services in a timely manner to both the Implementation Team and TennCare. The IT will keep records and report to TENNCARE in what areas of the state an inadequate network exists. The CONTRACTOR will be notified when reports indicate a network deficiency and when recruitment of additional providers is necessary.
- b. Mental Health and Substance Abuse Services. In addition to the requirements specified in Section 2-3.5, the following requirements shall pertain to the coordination of mental health and substance abuse services for children in state custody:
 1. The CONTRACTOR shall not limit the types or number of behavioral services that may be provided by a Best Practice Network Primary Care Provider.
 2. The CONTRACTOR will direct its Best Practice Network Primary Care Providers to submit all claims for services with a primary behavioral health diagnosis code (ICD-9-CM 290.xx – 319.xx) to the CONTRACTOR for payment.
 3. Prior approval shall not be required by the CONTRACTOR or the BHO in order for a Best Practice Network Primary Care Provider to refer children in state custody to a BHO Provider.
 4. The CONTRACTOR shall provide a listing of credentialed BPN-PCPs to the BHO periodically to facilitate coordination of care.
- c. Service Authorization. At such time that a procedure is implemented and described by TENNCARE, the Implementation Team shall be contacted for disposition when a covered service has been requested by a health care provider for a child in or at risk of state custody, and the CONTRACTOR denies or otherwise fails timely to provide that service or approve a less intense service which the provider or DCS feels is inadequate. Effective upon receipt of any plan for children in State custody which has been provided and/or approved by the court, the role of the Implementation Team may be modified.

- d. Services While Transitioning Out of Custody. Children transitioning out of State custody, shall continue to have access to Best Practice Network providers for a minimum period of six months unless specified otherwise by TENNCARE. The child transitioning out of state custody will remain in the CONTRACTOR's plan and the CONTRACTOR will continue to provide services in accordance with this Agreement, or any plan for Children in State custody which has been provided and/or approved by the court, unless the child's legal guardian elects for the child to receive services outside of the Best Practice Network. All services for "children in state custody" in this Agreement are applicable to children transitioning out of state custody for the time period specified by TENNCARE, which shall be six months unless otherwise specified by TENNCARE.

When a child goes home for a 90-day trial but is still in State custody, this will count for the first three months of transition time. The above services can also be continued for an additional number of months to be specified by TENNCARE, which shall be six months unless otherwise specified by TENNCARE, on a case by case basis for a total of 365 days from the time of custody termination for those children whom DCS or the PCP and the Implementation Team deem it appropriate to prevent them from returning to state custody.

- e. Children at Prolonged Risk of State Custody. Children that are deemed to be at prolonged risk of custody (to be defined by the Steering Panel) and that are identified to the CONTRACTOR by the state may continue to receive services through the Best Practice Network indefinitely.

- 52. Section 3-1.9 shall be amended by deleting parts a and b in their entirety and numbering the existing part c so that the amended Section 3-1.9 shall read as follows:

3-1.9 Performance Guarantees

The CONTRACTOR agrees to be bound by the performance guarantees identified below for the duration of this Agreement.

- a. **Provider Training Participation**

BPN provider training participation at least once a year by teleconference, interactive internet program or in-person.

Penalty for compliance:	Non-	\$25,000 for failure to timely complete training survey as specified in Section 3-1.6
Measurement:		Timely submission of survey findings

- 53. Section 4-1.2(b) shall be amended by adding a new phrase in the first sentence between the words "hospitals" and "identification" and by adding an additional phrase to the end of the first sentence so that the amended Section 4-1.2(b) shall read as follows:

4-1.2(b) Names, locations, telephone numbers, office hours, non-English languages spoken by current network providers (including primary care providers, specialists and hospitals, including locations of emergency settings and post stabilization services), identification of providers accepting new patients and whether or not a provider performs EPSDT

screens. In situations where there is more than one enrollee in a TennCare case, it shall be acceptable for the CONTRACTOR to mail one (1) provider directory to each address listed in the enrollees TennCare case number when there is more than one (1) new enrollee in a case at the time of enrollment and when subsequent updated provider directories are mailed to enrollees. These updates shall be maintained in accordance with Section 2-1.o of this Agreement.

54. Section 3-2 shall be amended by deleting and replacing part b and by adding a new part f so that the amended Section 3-2 shall read as follows:

3-2 Department of Children's Services Responsibilities

The Department of Children's Services shall be responsible for the following requirements related to the responsibilities of the CONTRACTOR:

- a. Notify the CONTRACTOR when a child enters state custody so that Immediate Eligibility can be established.
- b. Maintain responsibility of seeing that children in custody receive appropriate health services, including arranging appointments timely for EPSDT screenings to be performed at the local health department.. Report on number of children receiving EPSDT screenings in timely fashion.
- c. Provide care coordination and case management consistent with the *John B* Consent Decree and Medicaid regulations.
- d. Provide a representative to the CSHN Steering Panel.
- e. Provide training to staff to carry out the components of this plan.
- f. Provide medical information to child's assigned PCP in a timely manner and ensure follow up care is done by the PCP for any problems identified during the child's EPSDT screening.

55. Section 3 shall be amended by adding a new Section 3-5 which shall read as follows:

3-5 Department of Health

The Department of Health, through the local county health departments shall be responsible for the following:

- a. Shall ensure that they can meet the timeframe of offering DCS children an appointment for an EPSDT screening within 21 days of request by DCS, but not to exceed thirty (30) days of placement in state custody.
- b. Provide a letter to the DCS Case Manager and the child's assigned primary care provider confirming whether all seven components of the EPSDT screening were completed and stating any concerns that should be referred to the primary care provider for follow up .
- c. Provide the DCS Case Manager and the child's assigned primary care provider a letter stating the results of any lab tests performed on the child.

56. Section 4-1.2(c) shall be amended by adding new text to the end of the existing text so that the amended Section 4-1.2(c) shall read as follows:

4-1.2(c) The CONTRACTOR shall provide all other information as required by CMS, including but not limited to the following:

The following information to any enrollee who requests it:

- (a) information regarding the structure and operation of the CONTRACTOR's plan; and
- (b) information regarding Physician Incentive Plans, including but not limited to:
 - (i) Whether the CONTRACTOR uses a physician incentive plan that affects the use of referral services.
 - (ii) The type of incentive arrangement.
 - (iii) Whether stop-loss protection is provided.
 - (iv) If the CONTRACTOR was required to conduct a survey, a summary of the survey results.

57. Section 4-2.1.c shall be amended by adding a new Section 4-2.1.c.5., 6., and 7. which shall read as follows:

c. No enrollee shall be disenrolled from a health plan for any of the following reasons:

1. Adverse changes in the enrollee's health;
2. Pre-existing medical conditions;
3. High cost medical bills;
4. Failure or refusal to pay applicable cost-sharing fees, except when TENNCARE has approved such disenrollment;
5. Enrollee's utilization of medical services;
6. Enrollee's diminished mental capacity; or
7. Enrollee's uncooperative or disrupting behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees).

58. Section 5-2.1.a.2 shall be deleted in its entirety and the remaining parts in Section 5-2.1.a.2 shall be renumbered and references shall be update accordingly.

59. Effective July 1, 2003, Section 5-2.2 shall be deleted and re placed in its entirety so that the amended Section 5-2.2 shall read as follows:

5-2.2 Best Practice Network Requirements

- a. Enhanced Initial EPSDT Screening Rate. The CONTRACTOR shall make an enhanced payment to Best Practice Network Primary Care Providers and Health Departments for the initial EPSDT examination for children in state custody, when all seven (7) components of the exam have been completed. The seven components shall include: (1) A comprehensive health and development history to include both physical and mental health; (2) Comprehensive unclothed physical exam; (3) Appropriate vision and hearing assessment; (4) Laboratory testes appropriate for age and risk;

(5) Dental screening and referral beginning at age 3; (6) Immunizations; (7) Health education (anticipatory guidance).

1. The procedure codes to be utilized when billing for the initial EPSDT exam are specified below. This language does not preclude the BPN-PCP from billing for other services separately, consistent with the CONTRACTOR's procedures for claims processing (e.g., lab). It is the responsibility of the CONTRACTOR to include in its Best Practice Network provider agreements a requirement that all seven components of the EPSDT exam are completed when an enhanced payment is made through a medical chart review. The CONTRACTOR should educate providers to document any barriers to completing all seven components (e.g. past history not available). The enhanced payment rate for the initial EPSDT screening exam shall be ninety-five percent (95%) of the 2001 Medicare fee-schedule. Effective December 1, 2001, the enhanced fee schedule shall be 100% of the 2001 Medicare fee schedule unless otherwise specified by TENNCARE.

NEW PATIENT	ESTABLISHED PATIENT
99431 – History and Examination of Normal Newborn	99391 – Periodic reevaluation
99432 – Normal Newborn care other than a hospital or birthing setting	99392 – age 1 through 4 years
99381 – Initial evaluation	99393 – age 5 through 11 years
99382 – age 1 through 4 years	99394 – age 12 through 17 years
99383 – age 5 through 11 years	99395 – age 18 through 39 years
99384 – age 12 through 17 years	
99385 – age 18 through 39 years	

If the BPN-PCP submits a claim with a procedure code for an established patient, the CONTRACTOR may only reimburse the provider at the enhanced payment rate if the claim is for the initial EPSDT exam upon placement in state custody. If the CONTRACTOR directs BPN-PCPs to only bill the initial EPSDT exam with the New Patient procedure code series identified above, the CONTRACTOR must notify and provide appropriate training to the provider and provider's billing staff to implement this billing procedure.

- b. Case Management. In exchange for performing additional care coordination and case management functions as specified in Section 3 of this Agreement, the CONTRACTOR shall pay Best Practice Network Primary Care Providers a case management fee of \$10 per member per month.

60. Sections 5-3.d and e shall be deleted and replaced in their entirety so that the amended Sections 5-3.d and e shall read as follows:

- d. Pharmacy Rebates. The amount of pharmacy rebates collected by the CONTRACTOR for TennCare Select enrollees shall be the property of the State. On a quarterly basis, the CONTRACTOR shall notify the State and provide supporting documentation of the value of said rebates. The first claims payment remittance request following the receipt of rebates will be reduced by the value of the rebates reported. This documentation shall be required to continue until such time as the run out of all claims processed by the CONTRACTOR or its subcontracted pharmacy benefits manager (PBM), as directed by TENNCARE.

- e. Subrogation Recoveries. The CONTRACTOR shall be required to seek and collect third party subrogation amounts. The amount of any subrogation recoveries collected by the CONTRACTOR outside of the claims processing system shall be the property of the State. On a monthly basis, the CONTRACTOR shall report to the State the amount of any subrogation recoveries collected outside the claims processing system received during the previous month. The next remittance request subsequent to this monthly report shall be reduced by the value of the subrogation recoveries reported. Further, the CONTRACTOR shall provide any information necessary in a format and media described by TENNCARE and shall cooperate, as requested by TENNCARE, with TENNCARE and/or a Cost Recovery Vendor at such time that TENNCARE acquires said services.

Failure to seek, make reasonable effort to collect and report third party recoveries shall result in liquidated damages as described in Section 6-8 of this Agreement. It shall be the CONTRACTOR's responsibility to demonstrate, upon request, to TENNCARE that reasonable effort has been made to seek, collect and/or report third party recoveries. TENNCARE shall have the sole responsibility for determining whether or not reasonable efforts have been demonstrated.

61. Section 6-1 shall be amended by adding a new Section 6-1 q, renumbering the existing sections accordingly and adding new subsections t through cc which shall read as follows:

- 6-1. q. Investigatory Powers of the Tennessee Department of Commerce and Insurance pursuant to Tennessee Code Annotated Section 56-32-232.
- 6-1. t. Title IX of the Education Amendments of 1972 regarding education programs and activities.
- 6-1. u. Title 42 CFR 422.208 and 210, Physician Incentive Plans.
- 6-1. v. EEO Provisions.
- 6-1. w. Copeland Anti-Kickback Act .
- 6-1. x. Davis-Bacon Act.
- 6-1. y. Contract Work Hours and Safety Standards.
- 6-1. z. Rights to Inventions Made Under a Contract or Agreement.
- 6-1. aa. Byrd Anti-Lobbying Amendment.
- 6-1. bb. Contracts and subcontracts and subgrants of amounts in excess of \$100,000 shall require compliance with all applicable standards, orders or requirements issued under section 306 of the Clean Air Act (42 USC 1857 (h)), section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR part 15.)
- 6-1. cc. Mandatory standards and policies relating to energy efficiency which are contained in the State energy conservation plan issued in compliance with the Energy Policy and Conservation Act (Pub. L. 94-165.)

62. The first paragraph of Section 6-8.1 shall be amended by adding an additional phrase in the first sentence so that the amended Section 6-8.1 shall read as follows:

6-8.1 Intermediate Sanctions

TENNCARE may impose any or all of the sanctions as described in Section 6 upon TENNCARE's reasonable determination that the CONTRACTOR fails to comply with any corrective action plan (CAP) as described under Section 2-16 is otherwise deficient in the performance of its obligations under the Agreement, or has violated applicable requirements of Section 1903(m), Section 1905(t)(3) or 1932 of the Social Security Act, provided, however, that TENNCARE only impose those sanctions it determines to be appropriate for the deficiencies identified. TENNCARE may impose intermediate sanctions on the CONTRACTOR simultaneously with the development and implementation of a corrective action plan if the deficiencies are severe or numerous.

Intermediate sanctions may include:

1. application of liquidated damages as described in Section 6-2;
2. suspension of enrollment in the CONTRACTOR's MCO as described in Section 2-16;
3. disenrollment of enrollees as described in Section 2-22 and 4; or
4. limitation of the CONTRACTOR's Service Area as described in Section 2-22 and 4.

63. Item A.5 of the Liquidated Damage chart in Section 6-8.2.2 shall be deleted and replaced in its entirety and shall read as follows:

A.5(a)	Failure to provide a service or make payments for a service within five (5) calendar days of a reasonable and appropriate directive from TENNCARE to do so or within a longer period of time which has been approved by TENNCARE upon a plan's demonstration of good cause.	\$500 per day beginning on the next calendar day after default by the plan.
A.5(b)	Failure to provide proof of compliance to the Bureau Office of Contract Development and Compliance within five (5) calendar days of a reasonable and appropriate directive from TennCare or within a longer period of time which has been approved by TENNCARE upon a plan's demonstration of Good Cause.	\$500 per day beginning on the next calendar day after default by the plan.

64. Section 6-8 shall be amended by adding a new Item B.3 in the chart of liquidated damages which shall read as follows:

B.3	Failure to seek, collect and/or report third party recoveries to TENNCARE.	\$500 per day for each calendar day that TENNCARE determines the CONTRACTOR is not making reasonable effort to seek and collect third party recoveries.
------------	--	---

65. Section 6-8 shall be amended by adding new Sections 6-8.c and d which shall read as follows:

6-8.c. Sanctions by CMS

Payments provided for under this Agreement will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS in accordance with the requirements in 42 CFR 438.730.

6-8.d. Temporary Management

TENNCARE shall impose temporary management if it finds that the CONTRACTOR has repeatedly failed to meet substantive requirements in Section 1903(m) or Section 1932 of the Social Security Act.

66. Section 6-9 shall be amended by adding a new paragraph to the end of the existing text so that the amended Section 6-9 shall read as follows:

6-9 Renegotiation Procedures

Renegotiation procedures and criteria for amending this Agreement shall be as follows:

- a. For good cause, only at the end of the contract period; and
- b. For modification(s) during the contract period, if circumstances warrant.

This Agreement may be amended at anytime as provided in this paragraph. This Agreement shall be amended automatically without action by the parties whenever required by changes in state and federal law or regulations. In the event of a Partial Default, the Agreement shall be amended automatically to conform with written notices from TENNCARE of the CONTRACTOR regarding the effect of the Partial Default upon this Agreement. No other modification or change of any provision of the Agreement shall be made or construed to have been made unless such modification is mutually agreed to in writing by the CONTRACTOR and TENNCARE and incorporated as a written amendment to this Agreement prior to the effective date of such modification or change.

67. Section 6 shall be amended by adding a new Section 6-12 and renumbering the existing Sections 6-12 through 6-27 as Sections 6-13 through 6-28 and further amending all references thereto. The new Section 6-12 shall read as follows:

6-12. Lobbying

The Contractor further certifies by signing this Agreement, to the best of its knowledge and belief, that Federal funds have not been used for lobbying in accordance with 45 CFR 93, Appendix A.

68. Section 7-3.d and i shall be amended by adding new text to the end of the existing text of each section so that the amended Sections 7-3.d and i shall read as follows:

7-3.d. Drug formulary and all subsequent changes (applicable only if a closed formulary). Effective July 1, 2003, TENNCARE shall contract directly with a pharmacy benefits manager (PBM) for the provision of pharmacy services as described in Section 2-3.a.1 of this Agreement;

7-3.i. Alternative method of pharmacy restriction procedures for pharmacy abusers. Effective July 1, 2003, this shall no longer be a responsibility of the CONTRACTOR as TENNCARE shall contract directly with a PBM for the provision of pharmacy services as described in Section 2-3.1;

69. Section 7-11 shall be amended by adding new Sections 7-11.d and e so that the amended Section 7-11 shall read as follows:

7-11 Services Provided by TennCare

TennCare shall be responsible for the payment of the following services:

- a. For qualified individuals in accordance with TennCare policies and/or TennCare rules and regulations, costs of long term care institutional services in a nursing home, or an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or waiver-covered services provided through the Home and Community Based Services (HCBS) waivers, with the exception of the first one hundred (100) days of convalescent care, as described in Section 2-3.1 and 2-3.7 of this Agreement;
- b. Medicare buy-in premiums, Medicare deductibles and Medicare coinsurance amounts for enrollees who are dually eligible for Medicare and Medicaid; and
- c. Pharmacy Benefits for Medicare and TennCare dual eligibles after TENNCARE has notified the CONTRACTOR through the regular electronic eligibility update that these individuals are eligible in the TennCare/Medicare dual eligible category.
- d. Effective October 1, 2002, dental services as described in Sections 2-3.a.1 and 2-3.c.3 of this Agreement; and
- e. Effective July 1, 2003, all TennCare pharmacy benefits as described in Section 2-3.a.1 of this Agreement.

70. Items E and J of Part I of Attachment I shall be amended by adding additional language so that the amended Items E and J shall read as follows:

E. Drug Formulary (if closed) TENNCARE has thirty (30) calendar days to respond
(Effective July 1, 2003, the
TENNCARE shall contract
directly with a pharmacy
benefits manager for pharmacy
services as described in Section
2-3.a.1 of this Agreement.)

J. Method of pharmacy restriction TENNCARE has thirty (30) calendar days to respond
procedures for Pharmacy
Abusers
Effective July 1, 2003, the
TENNCARE shall contract
directly with a pharmacy
benefits manager for pharmacy
services as described in Section
2-3.a.1 of this Agreement
At such time, the
CONTRACTOR shall comply
with TennCare Policy regarding
Pharmacy Abusers.

71. Item C of Part II of Attachment I shall be amended by adding new text to the end of the existing text so that the amended Item C shall read as follows:

C Complete Drug Formulary; if January 1 of each year to TENNCARE Pharmacy
CONTRACTOR utilizes a closed Director
drug formulary, and a complete
description of prior authorization
criteria for each drug requiring prior
authorization via electronic file in
accordance with Section 3-13

(Effective July 1, 2003, the
TENNCARE shall contract directly
with a pharmacy benefits manager for
pharmacy services as described in
Section 2-3.a.1 of this Agreement.)

72. Item C of Part III of Attachment I shall be amended by adding a new sentence to the end of the text so that the amended Item C shall read as follows:
- C. Medicare/TennCare dual eligible pharmacy information monthly. Effective July 1, 2003, all TennCare covered pharmacy services shall be provided through a TennCare contracted pharmacy benefits manager (PBM). At such time, all pharmacy information shall be provided monthly.
73. Attachment II, Standard X.A.7 shall be amended by adding an additional phrase to the end of the existing text so that the amended Standard X.A.7 shall read as follows:
7. to have access to his/her medical records in accordance with applicable Federal and State laws and to request that they be amended or corrected, as specified in 45 CFR, part 164.
74. Attachment XII, Exhibit H shall be deleted in its entirety and shall be left blank intentionally.
75. Attachment XII, Exhibit L shall be amended by deleting Exhibit L.5 and renumbering the existing L.6 as L.5 and by separating the "Dual Eligible" column in Exhibits L.1 through L.5 into two columns which shall represent "Dual Eligible/Medicaid" and "Dual Eligible Standard".

ATTACHMENT XII, EXHIBIT H

Left Blank Intentionally

All of the provisions of the original Agreement not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective July 1, 2003 or as of the date it is approved by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: M. D. Goetz, Jr. JL
M. D. Goetz, Jr.
Commissioner

DATE: 6/30/03

APPROVED BY:

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: M. D. Goetz, Jr. RB
M. D. Goetz, Jr.
Commissioner

DATE: JUL 01 2003

VOLUNTEER STATE HEALTH PLAN, INC.

BY: Ronald E. Harr
Ronald E. Harr
President and CEO

DATE: 6-30-03

APPROVED BY:

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

BY: John G. Morgan out
John G. Morgan
Comptroller

DATE: 7-02-03

CONTRACT SUMMARY SHEET

Number: 318.66-026	Contract Number: FA-02-14632-02
Agency: Department of Finance and Administration	Division: Bureau of TennCare
Contractor	Contract Identification Number
(TennCare Select)	<input type="checkbox"/> V- <input type="checkbox"/> C-

Service Description

Medicaid Managed Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medicaid Population

Contract Begin Date	Contract End Date
7/1/2001	12/31/2003

Account Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66	839	134	11	<input type="checkbox"/> STARS		
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)	
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$ 18,599,868.48	
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$ 33,079,942.80	
2004	\$ 9,183,472.25	\$ 9,183,472.25			\$ 18,366,944.50	
Total:	\$ 31,724,532.88	\$ 38,322,222.90			\$ 70,046,755.78	

FDA# 93.778	Check the box ONLY if the answer is YES:
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State Fiscal Contract	Is the Contractor a SUBRECIPIENT? (per OMB A-133)
Contact: Dean Daniel 729 Church Street Nashville, TN (615)532-1362	Is the Contractor a Vendor? (per OMB A-133)
	Is the Fiscal Year Funding STRICTLY LIMITED?
	Is the Contractor on STARS?
	Is the Contractor's FORM W-9 ATTACHED?
Procuring Agency Budget Officer Approval Signature Daniel <i>Dean Daniel</i>	Is the Contractor's Form W-9 Filed with Accounts?

COMPLETE FOR ALL AMENDMENTS (only)			Funding Certification	
	Base Contract & Prior Amendments	This Amendment ONLY	Pursuant to T.C.A., Section 9-6-113, I, C. Warren Neel, Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.	
CONTRACT END DATE:	12/31/2003			
2002	\$ 18,599,868.48			
2003	\$ 28,036,976.80	\$ 5,042,966.00		
2004	\$ 18,366,944.50			
Total:	\$ 65,003,789.78	\$ 5,042,966.00		

RECEIVED
 2003 MAY 29 PM 3:1
 COMPTROLLER'S OFFICE
 OFFICE OF
 MANAGEMENT SERVICES

AMENDMENT NUMBER 2

AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.

CONTRACT NUMBER: FA-02-14632-02

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Agreement for the Administration of TennCare Select by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as follows:

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. Section 2 of the Agreement for the Administration of TennCare Select shall be amended by adding a new Section 2-25 which shall read as follows:

2-25. Processing and Payment of Supplemental Payments

Subject to the availability of State funding, the CONTRACTOR agrees to make a supplemental pool payment to Meharry Medical Services Foundation or Meharry Dental Clinic. These payments represent unreimbursed TennCare costs of the Meharry Medical College clinics as determined by a review of an independent CPA and in accordance with the methodology approved by the Centers for Medicare and Medicaid Services. Clinical services are performed by Meharry Medical College faculty physicians through the Meharry Dental Clinic and the Meharry Medical Services Foundation. The payment by the CONTRACTOR to the clinic(s) will be made within 10 calendar days of the receipt of such payment by the CONTRACTOR from TENNCARE. The CONTRACTOR may deposit these funds in the account of its choice and may retain all interest earned as compensation for providing this service. The CONTRACTOR agrees to include any correspondence requested by TENNCARE to be included with the payment and provide a written confirmation of any disbursements including the date the check was mailed and the date redeemed.

Payments to the Meharry Medical Services Foundation and/or the Meharry Dental Clinic under this amendment shall not exceed \$4,942,107 for State fiscal year 2003. In addition to any interest earned, TENNCARE agrees to pay the CONTRACTOR a sum sufficient to administer this amendment in accordance with state law. The total obligation to the CONTRACTOR under this amendment including the supplemental payment to Meharry Medical Services Foundation and/or the Meharry Dental Clinic shall not exceed \$5,042,966 for State fiscal year 2003.

Amendment 2 (continued)

All of the provisions of the original Agreement not specifically deleted or modified herein shall remain in full force and effect. For purposes of the provisions contained herein, this Amendment shall become effective upon signature by all parties and federal participation will be drawn upon approval by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: M. D. Goetz Jr.
M. D. Goetz, Jr.
Commissioner

DATE: 5/29/03

VOLUNTEER STATE HEALTH PLAN,
INC.

BY: Ron E. Harr
Ron E. Harr
President and Chief Executive Officer

DATE: 5/29/03

APPROVED BY:

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: M. D. Goetz Jr.
M. D. Goetz, Jr.
Commissioner

DATE: MAY 29 2003

APPROVED BY:

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

BY: John G. Morgan
John G. Morgan
Comptroller

DATE: 5/29/03

CONTRACT SUMMARY SHEET

RFS Number:	318.66-026	Contract Number:	FA-02-14632-01
State Agency:	Department of Finance and Administration	Division:	Bureau of TennCare

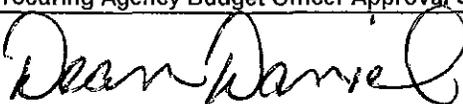
Contractor	Contract Identification Number
VSHP (TennCare Select)	<input type="checkbox"/> V- <input type="checkbox"/> C-

Service Description

Managed Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medicaid Population

Contract Begin Date	Contract End Date
7/1/2001	12/31/2003

Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66	839	134	11	<input type="checkbox"/> STARS		
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)	
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$	18,599,868.48
2003	\$ 14,018,488.40	\$ 14,018,488.40			\$	28,036,976.80
2004	\$ 9,183,472.25	\$ 9,183,472.25			\$	18,366,944.50
Total:	\$ 29,957,897.88	\$ 35,045,891.90			\$	65,003,789.78

CFDA#	93.778	Check the box ONLY if the answer is YES:
State Fiscal Contract		Is the Contractor a SUBRECIPIENT? (per OMB A-133)
Name:	Dean Daniel	Is the Contractor a Vendor? (per OMB A-133)
Address:	729 Church Street	Is the Fiscal Year Funding STRICTLY LIMITED?
Phone:	Nashville, TN (615)532-1362	Is the Contractor on STARS?
Procuring Agency Budget Officer Approval Signature		Is the Contractor's FORM W-9 ATTACHED?
Dean Daniel		Is the Contractor's Form W-9 Filed with Accounts?

COMPLETE FOR ALL AMENDMENTS (only)			Funding Certification
	Base Contract & Prior Amendments	This Amendment ONLY	Pursuant to T.C.A., Section 9-6-113, I, C. Warren Neel, Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.
CONTRACT END DATE:	12/31/2002	12/31/2003	
FY: 2002	\$ 18,599,868.48		
FY: 2003	\$ 9,670,032.30	\$ 18,366,944.50	
FY: 2004		\$ 18,366,944.50	
FY:			
Total:	\$ 28,269,900.78	\$ 36,733,889.00	

RECEIVED
 2002 DEC 10 PM 2:22
 COMPTROLLER'S OFFICE
 OFFICE OF
 MANAGEMENT SERVICES

AMENDMENT NUMBER 1

AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.

CONTRACT NUMBER: FA-02-14632-01

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Amended and Restated Contractor Risk Agreement by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Volunteer State Health Plan, Inc., hereinafter referred to as the CONTRACTOR, as follows:

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language..

1. Section 1-1 shall be amended by deleting "Mark E. Reynolds", deleting "Vicky Gregg" and inserting "Mark Austin" in place of "Vicky Gregg" so that the title and address for the notice to TENNCARE shall read as follows:

If to TENNCARE:

Deputy Commissioner
Bureau of TennCare
729 Church Street
Nashville, Tennessee 37247-6501

If to the CONTRACTOR:

Mark Austin
President and CEO
801 Pine Street
Chattanooga, Tennessee 37402-2555

2. Section 1-3 shall be amended by deleting the following definitions: "Behavioral Health Referral Center", "Executive Oversight Committee", "HCFA", "MCO and BHO Coordination Agreement", "Remedial Plan" and "Revised Remedial Plan", and renumbering the definitions in Section 1-3 accordingly.
3. Section 1-3 shall be amended by deleting and replacing the definition of "Administrative Cost" so that the amended definition shall read as follows:

Administrative Cost – All costs to the Contractor related to the administration of this Agreement that are non-medical in nature, including, but not limited to:

- Satisfying Contractor Qualifications specified in Sections 2-1 and 2-2;
- Establishing and Maintaining a Provider Network in accordance with the Access and Availability requirements specified in Section 2-4.1, Attachment III and Attachment IV;

Amendment 1 (continued)

- Determination and production of recoveries from Third Party Liability resources in accordance with Section 2-9.8;
- Claims Processing in accordance with Section 2-9.7;
- Administration of this Agreement in accordance with Medical Management Policies and Procedures including: Utilization Management policies and procedures, including prior authorization policies and procedures established in accordance with Section 2-7.1; Referral and Exemption Requirements established in accordance with Section 2-4.4; Out of Area or Out of Plan Use policies and procedures established in accordance with Section 2-4.7; Transplant policies and procedures established in accordance with Section 2-3.12; Prescription Drug Formulary established in accordance with Section 2-3.13; Prenatal Care policies and procedures established in accordance with Section 2-7.1.f.3 and 2-3.15; Quality Monitoring/Quality Improvement Program established in accordance with Section 2-9.6; Management of Medical Care and Coordination of Care policies and procedures established in accordance with Sections 2-4.2 and 2-4.3;
- Enrollment and Disenrollment in accordance with Section 4;
- Appeals processing and resolution in accordance with Section 2-8;
- Quality Assurance and Improvement activities as specified in Section 2-9.6 and Attachment II;
- Production and submission of required reports as specified in Section 2-10;
- Production and distribution of Marketing and Enrollee Materials as specified in Section 2-6;
- All other Administration and Management responsibilities as specified in Sections 2-11 through 2-24 and other activities required to be conducted in Attachment I, V, VI, VII, XI, XII, XIII; and
- All costs related to third party recovery or subrogation activities whether performed by the Contractor or a subcontractor.

Costs of subcontractors engaged solely to perform a non-medical administrative function for the CONTRACTOR specifically related to securing or fulfilling the CONTRACTOR's obligations to TENNCARE under the terms of this Agreement (e.g., claims processing, marketing) are considered to be an "administrative cost".

4. Section 1-3 shall be amended by adding a definition for "Behavioral Health Services" and renumbering the existing definitions as appropriate. The new definition for "Behavioral Health Services" shall read as follows:

Behavioral Health Services – Generally recognized and accepted mental health and substance abuse services.

5. Section 1-3 shall be amended by deleting and replacing in its entirety the definition for "Children with Special Health Needs Steering Panel (CSHN Steering Panel)" so that the amended definition shall read as follows:

Children with Special Health Needs Steering Panel (CSHN Steering Panel) - An entity comprised of representatives of providers, advocates, the State, the plaintiffs of the court order related to the provision of services to children in State custody, managed care entities, and referral sites whose responsibility will be to guide and assess the development of a health service system for children in state custody, and where appropriate, make recommendations.

6. Section 1-3 shall be amended by adding a definition for "CMS" and renumbering existing definitions as appropriate and the existing references to "HCFA" throughout the Agreement (except for the definition) shall be replaced by "CMS". The new definition for CMS shall read as follows:

CMS - Centers for Medicare & Medicaid Services [formerly Health Care Financing Administration (HCFA)].

Amendment 1 (continued)

7. Section 1-3 shall be amended by deleting and replacing in its entirety the definition for "Health Services Team/Implementation Team" so that the amended definition shall read as follows:

Implementation Team - A team consisting of a physician, mental health professional(s) and other support(s) who are charged with staffing the steering panel and implementing the plan for children in State custody which has been provided and/or approved by the court as directed by TennCare.

8. Section 1-3 shall be amended by adding a definition for "Immediate Eligibility" and "Long-term care" and renumbering existing definitions as appropriate. The definitions for "Immediate Eligibility" and "Long-term care" shall read as follows:

Immediate Eligibility -- Temporary eligibility granted to a child upon entering into State custody in order to give children in State custody adequate access to medical services, including EPSDT, until a final determination can be made on their TennCare eligibility.

Long-term care -- the services of one of the following: a nursing facility (NF); An Intermediate Care Facility for the Mentally Retarded (ICF/MR), or a Home and Community-Based Services (HCBS) waiver program. (Services provided under a HCBS waiver program are considered to be alternatives to long-term care).

9. Effective January 1, 2003, the definition for "Medically Necessary" in Section 1-3 shall be amended by adding the words "TennCare Medicaid" in item "e" so that the amended definition for "Medically Necessary" shall read as follows:

Medically Necessary - Services or supplies provided by an institution, physician, or other provider that are required to identify or treat a TennCare enrollee's illness, disease, or injury and which are:

- a. Consistent with the symptoms or diagnosis and treatment of the enrollee's illness, disease, ailment, or injury; and
- b. Appropriate with regard to standards of good medical practice; and
- c. Not solely for the convenience of an enrollee, physician, institution or other provider; and
- d. The most appropriate supply or level of services which can safely be provided to the enrollee. When applied to the care of an inpatient, it further means that services for the enrollee's medical symptoms or condition require that the services cannot be safely provided to the enrollee as an outpatient; and
- e. When applied to TennCare Medicaid enrollees under 21 years of age, services shall be provided in accordance with EPSDT requirements including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.

10. The Definition for Non-Contract Provider shall be deleted and replaced in its entirety so that the amended definition shall read as follows:

Non-Contract Provider - Any person, organization, agency, or entity that is not directly or indirectly employed by or under contract with the CONTRACTOR or any of its subcontractors pursuant to the Agreement between the CONTRACTOR and TENNCARE.

Amendment 1 (continued)

11. Section 1-3 shall be amended by adding the following new definitions:

TennCare Medicaid Enrollee – an enrollee who qualifies and has been determined eligible for benefits in the TennCare program through Medicaid eligibility criteria as described in the Medicaid/TennCare Rules and Regulations.

TennCare Standard Enrollee – an enrollee who qualifies and has been determined eligible for benefits in the TennCare program through eligibility criteria designated as “TennCare Standard” as described in the TennCare Program Design and Waiver Modifications submitted February 12, 2002 to CMS, as approved May 30, 2002, and the TennCare Rules and Regulations.

12. Section 2-1.i shall be amended by adding references “2-4.10 and 2-10.16” to the first sentence of the third paragraph.

13. Section 2-1.k shall be amended by adding a new sentence to the end of the existing paragraph so that the amended Section 2-1.k shall read as follows:

k. Unanimously agree with other MCOs in the TennCare system for the provision of pharmacy services to TennCare enrollees who reside in long-term care facilities (nursing homes) so that only one pharmacy (unit dose vendor) shall be responsible for the provision of pharmacy services to all TennCare enrollees in each nursing home. The scope of pharmacy services available to long-term care facility residents shall be the scope of pharmacy services available under the MCO plan to enrollees not residing in the long-term care facility. The MCOs will agree on the pharmacy providing the services and the formulary used in each facility; however, the rates of reimbursement, claims submission methods and payment schedules for pharmacy services will be determined by each individual MCO plan. The agreed upon formulary is a minimum listing of covered drugs, nothing herein prohibits an MCO from covering additional drugs not included in the aforementioned agreed upon listing.

14. Section 2-1.m shall be deleted and replaced in its entirety so that the amended Section 2-1.m shall read as follows:

m. Agree to report all provider related data required pursuant to this Agreement to TENNCARE using a uniform provider number (i.e., All MCOs must transmit each provider related record to TENNCARE using the same provider identification number regardless of which or how many MCOs the provider participates in). The uniform number to be reported for all providers except pharmacy will be the traditional “Medicaid” provider number. Prior to payment of a claim, the MCO shall require that providers that have not been enrolled in the TennCare Program previously as a Medicaid provider or as a provider who currently receives direct payment from TENNCARE (i.e., Medicare cost sharing) contact the Medicaid/TennCare Provider Enrollment Unit and obtain a “Medicaid” provider number. The issuance of a provider number by TennCare is simply for the purpose of establishing a common provider number for reporting purposes as required by this Section and does not imply any enrollment in the TennCare program or that TENNCARE has credentialed the provider or convey any other contractual relationship or any other responsibility with the provider. Pharmacy providers shall use the National Association Board of Pharmacy (NABP) number that has been assigned. Effective October 1, 2002, the CONTRACTOR shall capture and report a valid DEA number as the identification number for pharmacy claims and encounter data as required in Attachment XII, Exhibit G of this Agreement. CONTRACTOR agrees that at such time that the Centers for Medicare & Medicaid Services establishes a national uniform identification number, at the State’s request, the CONTRACTOR shall agree to utilize CMS’s newly established uniform provider numbers for all provider reporting purposes in accordance with timeframes established by CMS.

15. Section 2-1 shall be amended by adding a new Part t which shall read as follows:

- t. Agree to educate and encourage providers to submit claims with appropriate codes and modifiers as described in standardized billing requirements (e.g., CPT, HCPCS, etc) and adjust billing methodology according to described components of said procedure codes/modifiers.

16. Section 2-2 shall be deleted and replaced in its entirety so that the amended Section 2-2 shall read as follows:

2-2 Requirements for Children in State Custody

- a. The CONTRACTOR shall develop and maintain a Best Practice Network of providers with the appropriate expertise and experience and willingness in the special health care needs of children in state custody.
- b. The CONTRACTOR hereby agrees to serve as the designated carve-out MCO for the purpose of meeting the needs of children in state custody and agrees to satisfy all special requirements for the delivery of services to children in state custody. The CONTRACTOR further agrees that at such time that any plan for children in State custody is provided and/or approved by the court, the CONTRACTOR shall administer this Agreement in accordance with the requirements of the court order. In the event that TENNCARE makes a determination that the requirements of the court order differ materially from the requirements specified in this Agreement, TENNCARE and the CONTRACTOR agree to negotiate the required amendments to this Agreement for the purpose of incorporating the requirements of the court order. TENNCARE and the CONTRACTOR recognize and agree that said amendment shall reflect mutually agreed upon additional costs to the CONTRACTOR, if any, related to the requirements of the court order, which must be documented by the CONTRACTOR and approved by TENNCARE, for which TENNCARE will compensate the CONTRACTOR.

17. Section 2-3.1 shall be deleted in its entirety and replaced by a new Section 2.3.1 which shall read as follows:

2-3.1 Covered Benefits

Effective January 1, 2003, benefits in the TennCare Program as provided by the CONTRACTOR are based on the following categories of enrollee eligibility: TennCare Medicaid; and TennCare Standard.

The CONTRACTOR shall cover the services and benefits as outlined below.

2-3.1.1 TennCare Benefits, prior to January 1, 2003:

SERVICE	BENEFIT
Inpatient Hospital Services	As medically necessary. Pre-admission approval and concurrent reviews allowed.
Outpatient Hospital Services	As medically necessary.

Amendment 1 (continued)

Physician Inpatient Services	As medically necessary. This shall include acupuncture performed by a Physician or a registered nurse as an anesthetic in connection with a surgical procedure.
Physician Outpatient Services/Community Health Clinic Services/Other Clinic Services	As medically necessary. This shall include acupuncture performed by a Physician or a registered nurse as an anesthetic in connection with a surgical procedure and services provided by a Primary Care Provider with a primary behavioral health diagnosis (ICD-9-CM 290.xx - 319.xx).
Lab & X-Ray Services	As medically necessary.
Hospice Care	As medically necessary. Must be provided by an organization certified pursuant to Medicare Hospice requirements.
Dental Services	<p>Effective October 1, 2002, the following covered dental services shall be provided by the TennCare Dental Benefits Manager: Preventive, diagnostic and treatment services for enrollees under age 21. Services for enrollees age 21 or older limited to cases of accidental injury to or neoplasms of the oral cavity; life threatening infections that include, but are not limited to, individuals with severely compromised immune systems, organ donor recipients, or individuals with or scheduled to receive a prosthetic heart valve(s), accidental injury to natural teeth including their replacement (limited to the cost of bridgework or the replacement of teeth injured in an accident unless teeth implants are medically necessary) and the removal of impacted wisdom teeth. (The adult dental "accident" must be caused by some external force, like a car accident, not by some normal act of mastication, or grinding of teeth while sleeping, or any other naturally occurring circumstance and must have occurred during a period of TennCare eligibility and within twelve (12) months from the date service is requested.) Orthodontics limited to individuals under 21 except when an orthodontic treatment plan is approved prior to the enrollee attaining 20 1/2 years of age, and treatment is initiated prior to the recipient attaining 21 years of age, or when orthodontic treatment is the result of facial hemiatrophy or congenital birth defects (if enrollee was covered by TennCare at birth).</p> <p>Effective October 1, 2002, CONTRACTOR shall provide transportation to and from said services as well as the medical and anesthesia services that are not provided by a dentist or in a dentist's office related to the dental service.</p>
Vision Services	Preventive, diagnostic and treatment services (including eyeglasses) for enrollees under age 21. The first pair of cataract glasses or contact lens/lenses following cataract surgery is covered for adults.
Home Health Care	As medically necessary.

<p>Pharmacy Services (obtained directly from an ambulatory retail pharmacy setting, outpatient hospital pharmacy, mail order pharmacy or those administered to a long-term care facility resident (nursing facility))</p>	<p>As medically necessary. Non-covered therapeutic classes as described in Section 2-3.13, DESI, LTE, IRS drugs excluded.</p> <p>TENNCARE is responsible for the provision and payment of pharmacy benefits to individuals who are enrolled in the TennCare Program in the category of TennCare Medicaid/Medicare dual eligible. (However, this does not include pharmaceuticals administered in a doctor's office.)</p> <p>TENNCARE is not responsible for the provision and payment of pharmacy services for TennCare Medicaid/Medicare dual eligibles prior to the date that TENNCARE has notified the CONTRACTOR through the regular electronic eligibility update that these individuals are eligible in the TennCare/Medicare dual eligible category.</p>
<p>Durable Medical Equipment</p>	<p>As medically necessary.</p>
<p>Medical Supplies</p>	<p>As medically necessary.</p>
<p>Emergency Ambulance Transportation</p>	<p>As medically necessary.</p>
<p>Non-Emergency Ambulance Transportation</p>	<p>As medically necessary.</p>
<p>Non-Emergency Transportation</p>	<p>As necessary for enrollees lacking accessible transportation for covered services.</p> <p>The travel to access primary care and dental services must meet the requirements of the waiver terms and conditions. The availability of specialty services as related to travel distance should meet the usual and customary standards for the community. However, in the event the MCO is unable to negotiate such an arrangement for an enrollee, transportation must be provided regardless of whether or not the enrollee has access to transportation. If the enrollee is a child, transportation must be provided for the child and an accompanying adult. However, transportation for a child shall not be denied pursuant to any policy which poses a blanket restriction due to enrollee's age or lack of parental accompaniment. Any decision to deny transportation of a child due to an enrollee's age or lack of parental accompaniment must be made on a case-by-case basis and must be based on the individual facts surrounding the request. As with any denial, all notices and actions must be in accordance with the appeal process.</p> <p>At such time that TENNCARE carves out the CONTRACTOR's responsibility to provide Dental Services, the provision of transportation to and from said services shall remain with the CONTRACTOR.</p>

Community Health Services	As medically necessary.
Renal Dialysis Services	As medically necessary.
EPSDT Services for enrollees under age 21 in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.	Screening, interperiodic screening, diagnostic and follow-up treatment services as medically necessary in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989 for enrollees under 21. Except for Dental services, screens shall be in accordance with the periodicity schedule set forth in the latest "American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care" and all components of the screens must be consistent with the latest "American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care". Dental screens shall be in accordance with the latest periodicity schedule set forth by the American Academy of Pediatric Dentistry and all components of the screens must be consistent with the latest recommendations by the American Academy of Pediatric Dentistry. Tools to be used for screenings shall be consistent with the EPSDT Screening Guidelines as described in Attachment VIII of the Agreement. EPSDT services also include maintenance services which are services which have been determined to be effective in preventing or mitigating the worsening of an individual's conditions or preventing the development of additional health problems.
Rehabilitation Services	As medically necessary when determined cost effective by the MCO. All medically necessary services shall be provided to enrollees under 21 years of age in accordance with EPSDT requirements including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.
Chiropractic Services	When determined cost effective by the MCO.
Private Duty Nursing	As medically necessary and when prescribed by an attending physician for treatment and services rendered by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), who is not an immediate relative.

<p>Speech Therapy</p>	<p>As medically necessary, by a Licensed Speech Therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic or personality disorder. All medically necessary services shall be provided to enrollees under 21 years of age in accordance with EPSDT requirements including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.</p>
<p>Sitter</p>	<p>As medically necessary, a sitter who is not a relative may be used where an enrollee is confined to a hospital as a bed patient and certification is made by a network physician that R.N. or L.P.N. is needed and neither is available.</p>
<p>Convalescent Care</p>	<p>Upon receipt of proof that a Covered Person has incurred Medically Necessary expenses related to convalescent care, the Plan shall pay for up to and including the one-hundredth (100th) day of confinement during any calendar year for convalescent facility(ies) room, board and general nursing care, provided: (1) a Physician recommends confinement for convalescence; (2) the enrollee is under the continuous care of a Physician during the entire period of confinement; and (3) the confinement is required for other than custodial care.</p>
<p>Organ Transplants and Donor Organ Procurement</p>	<p>As medically necessary for a covered organ transplant.</p>
<p>Reconstructive Breast Surgery</p>	<p>Covered in accordance with TCA 56-7-2507 which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy as well as any surgical procedure on the non-diseased breast deemed necessary to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast to establish symmetry with the diseased breast will only be covered if the surgical procedure performed on a non-diseased breast occurs within five (5) years of the date the reconstructive breast surgery was performed on a diseased breast.</p> <p>Note: Applicable CPT procedure codes regarding the revision of undiseased breast following mastopexy or mastectomy for breast cancer, for the purpose of restoring symmetry, shall be the CPT procedures codes in the following range: 19316 – 19396.</p>

2-3.1.2 TennCare Medicaid benefits, effective January 1, 2003:

Service	Coverage Provided by TennCare Medicaid
<p>Inpatient Hospital Services</p>	<p>As medically necessary. CONTRACTOR may conduct concurrent and retrospective review.</p> <p>Age 21 and older: Inpatient rehabilitation hospital facility services may be covered when determined to be a cost-effective alternative by the MCO.</p> <p>Under age 21: As medically necessary, rehabilitation hospital facility services are covered under EPSDT.</p>
<p>Outpatient Hospital Services</p>	<p>As medically necessary.</p>
<p>Physician Inpatient Services</p>	<p>As medically necessary.</p>
<p>Physician Outpatient Services/Community Health Clinic Services/Other Clinic Services</p>	<p>As medically necessary. This shall include services provided by a Primary Care Provider with a primary behavioral health diagnosis (ICD-9-CM 290.xx - 319.xx).</p>
<p>EPSDT Services for enrollees under age 21 in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.</p>	<p>Age 21 and older: not covered.</p> <p>Under age 21: Covered as medically necessary, except that the screenings do not have to be medically necessary. Children may also receive screenings in-between regular checkups if a parent or caregiver believes there is a problem.</p> <p>Screening, interperiodic screening, diagnostic and follow-up treatment services as medically necessary in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989 for enrollees under 21. Except for Dental services, screens shall be in accordance with the periodicity schedule set forth in the latest "American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care" and all components of the screens must be consistent with the latest "American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care". Dental screens shall be in accordance with the latest periodicity schedule set forth by the American Academy of Pediatric Dentistry and all components of the screens must be consistent with the latest recommendations by the American Academy of Pediatric Dentistry.</p>
<p>Lab and X-ray Services</p>	<p>As medically necessary.</p>

<p>Hospice Care</p>	<p>As medically necessary. Must be provided by a Medicare-certified hospice.</p>
<p>Dental Services</p>	<p>The following covered dental services shall be provided by the TennCare Dental Benefits Manager: preventive, diagnostic and treatment services for enrollees under age 21. Services for enrollees age 21 or older limited to cases of accidental injury to or neoplasm of the oral cavity, life threatening infections that include, but are not limited to, individuals with severely compromised immune systems, organ donor recipients, or individuals with or scheduled to receive a prosthetic heart valve(s), accidental injury to natural teeth including their replacement (limited to the cost of bridgework of the replacement of teeth injured in an accident unless teeth implants are medically necessary) and the removal of impacted wisdom teeth. (The adult dental "accident" must be caused by some external force, like a car accident, not by some normal act of mastication, or grinding of teeth while sleeping, or any other naturally occurring circumstance and must have occurred during a period of TennCare eligibility and within twelve (12) months from the date service is requested.) Orthodontics limited to individuals under 21 except when an orthodontic treatment plan is approved prior to the enrollee attaining 20 1/2 years of age, and treatment is initiated prior to the recipient attaining 21 years of age, or when orthodontic treatment is the result of facial hemiatrophy or congenital birth defects (if enrollee was covered by TennCare at birth).</p> <p>The CONTRACTOR shall provide transportation to and from said services as well as the medical and anesthesia services that are not provided by a dentist or in dentist's office related to the dental service.</p> <p>(See Section 2-3.4)</p>
<p>Vision Services</p>	<p>Age 21 and older: Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of refractive state), will be covered. Routine periodic assessment, evaluation, or screening of normal eyes and examinations for the purpose of prescribing fitting or changing eyeglass and/or contact lenses will not be covered.</p> <p>Under age 21: Preventive, diagnostic, and treatments services (including eyeglasses), are covered as medically necessary.</p>
<p>Home Health Care</p>	<p>Age 21 and older: As medically necessary, all home care as delivered by a licensed Home Health Agency, as defined by 42 CFR 440.70, limited to 125 visits per enrollee per calendar year (January – December)</p> <p>Under age 21: As medically necessary.</p> <p>A home health visit includes any of the following: Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Pathology and Audiology services, and Home Health Aide. Full-time nursing services are not covered for adults 21 years of age and over.</p>

Amendment 1 (continued)

<p>Pharmacy Services (obtained directly from an ambulatory retail pharmacy setting, outpatient hospital pharmacy, mail order pharmacy or those administered to a long-term care facility resident (nursing facility))</p>	<p>As medically necessary. Certain drugs (known as DESI, LTE, or IRS drugs) are excluded from coverage.</p> <p>TENNCARE is responsible for the provision and payment of pharmacy benefits to individuals who are enrolled in the TennCare Program in the category of TennCare Medicaid/Medicare dual eligible. (However, this does not include pharmaceuticals administered in a doctor's office.)</p> <p>TENNCARE is not responsible for the provision and payment of pharmacy services for TennCare Medicaid/Medicare dual eligibles prior to the date that TENNCARE has notified the CONTRACTOR through the regular electronic eligibility update that these individuals are eligible in the TennCare/Medicare dual eligible category.</p>
<p>Durable Medical Equipment</p>	<p>As medically necessary.</p>
<p>Medical Supplies</p>	<p>As medically necessary.</p>
<p>Emergency Air and Ground Ambulance Transportation</p>	<p>As medically necessary.</p>
<p>Non-emergency Transportation (including Non-Emergency Ambulance Transportation)</p>	<p>As necessary to get an enrollee to and from covered services, for enrollees not having access to transportation. MCOs may require advance notice of the need in order to timely arrange transportation.</p> <p>The travel to access primary care and dental services must meet the requirements of the waiver terms and conditions. The availability of specialty services as related to travel distance should meet the usual and customary standards for the community. However, in the event the MCO is unable to negotiate such an arrangement for an enrollee, transportation must be provided regardless of whether or not the enrollee has access to transportation. If the enrollee is a child, transportation must be provided for the child and an accompanying adult. However, transportation for a child shall not be denied pursuant to any policy which poses a blanket restriction due to enrollee's age or lack of parental accompaniment. Any decision to deny transportation of a child due to an enrollee's age or lack of parental accompaniment must be made on a case-by-case basis and must be based on the individual facts surrounding the request. As with any denial, all notices and actions must be in accordance with the appeal process.</p> <p>The CONTRACTOR shall provide transportation to and from dental services.</p>
<p>Community Health Services</p>	<p>As medically necessary.</p>
<p>Renal Dialysis Services</p>	<p>As medically necessary, for the first 90 days prior to being covered by Medicare.</p>

<p>Private Duty Nursing</p>	<p>Age 21 and older: Not covered.</p> <p>Under age 21: Covered as medically necessary in accordance with EPSDT requirements when prescribed by an attending physician for treatment and services rendered by an R.N. or a L.P.N. who is not an immediate relative.</p>
<p>Speech Therapy</p>	<p>Age 21 and older: Covered as medically necessary by a Licensed Speech Therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic or personality disorder.</p> <p>Under age 21: Covered as medically necessary in accordance with EPSDT requirements.</p>
<p>Occupational Therapy</p>	<p>Age 21 and older: Covered as medically necessary when provided by a Licensed Occupational Therapist to restore, improve, or stabilize impaired functions.</p> <p>Under age 21: Covered as medically necessary in accordance with EPSDT requirements.</p>
<p>Physical Therapy</p>	<p>Age 21 and older: Covered as medically necessary when provided by a Licensed Physical Therapist to restore, improve, or stabilize impaired functions.</p> <p>Under age 21: Covered as medically necessary in accordance with EPSDT requirements.</p>
<p>Organ Transplant And Donor Organ Procurement</p>	<p>Age 21 and older: All medically necessary and non-investigational/experimental organ transplants are covered. These include, but may not be limited to: Bone marrow/Stem cell; Cornea; Heart; Heart/Lung; Kidney; Kidney/Pancreas; Liver; Lung; Pancreas; and Small bowel/Multi-visceral.</p> <p>Under age 21: Covered as medically necessary in accordance with EPSDT requirements. Experimental or investigational transplants are not covered.</p>
<p>Reconstructive Breast Surgery</p>	<p>Covered in accordance with TCA 56-7-2507, which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy as well as surgical procedures on the non-diseased breast as deemed necessary to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast to establish symmetry with the</p>

	diseased breast will only be covered if the surgical procedure performed on a non-diseased breast occurs within five (5) years of the date the reconstructive breast surgery was performed on a diseased breast.
Bariatric Surgery, including, but not limited to, Gastric Stapling, Intestinal Bypass Surgery, and Banding	As medically necessary and provided in accordance with clinical guidelines established by the Bureau of TennCare.
Chiropractic Services	Age 21 and older: Not covered. Under age 21: Covered as medically necessary in accordance with EPSDT requirements.
Sitter Services	NOT COVERED
Convalescent Care	NOT COVERED

2-3.1.3 TennCare Standard benefits, effective January 1, 2003:

The following benefits will apply to all TennCare Standard enrollees except for individuals who were enrolled in TennCare as of December 31, 2001, with Medicare but not Medicaid coverage, and who continue to meet the criteria for "Uninsurable" status in place at that time. These individuals who were enrolled in TennCare as of December 31, 2001, with Medicare but not Medicaid coverage, and who continue to meet the criteria for "Uninsurable" status in place at that time will only be eligible for the TennCare Standard Pharmacy benefit package and shall not be the responsibility of the CONTRACTOR. The CONTRACTOR agrees to comply with policies and procedures to be provided by TennCare related to the continuation of services for persons whose eligibility changes from TennCare Medicaid to TennCare Standard and for whom services were previously authorized in accordance with the TennCare Medicaid benefit package.

Service	Coverage Provided by TennCare Standard
Inpatient Hospital Services	As medically necessary. CONTRACTOR may conduct concurrent and retrospective review. Inpatient Rehabilitation hospital facility services may be covered when determined to be a cost-effective alternative by the MCO.
Outpatient Hospital Services	As medically necessary.
Physician Inpatient Services	As medically necessary.

<p>Physician Outpatient Services/Community Health Clinic Services/Other Clinic Services</p>	<p>As medically necessary. This shall include services provided by a Primary Care Provider with a primary behavioral health diagnosis (ICD-9-CM 290.xx - 319.xx).</p>
<p>Lab and X-ray Services</p>	<p>As medically necessary.</p>
<p>Hospice Care</p>	<p>As medically necessary. Must be provided by an organization certified pursuant to Medicare hospice requirements.</p>
<p>Dental Services</p>	<p>The TennCare Dental Benefits Manager shall cover dental services in accordance with the following:</p> <p>Coverage for adults and children limited to cases of accidental injury to or neoplasm of the oral cavity, life threatening infections that include, but are not limited to, individuals with severely compromised immune systems, organ donor recipients, or individuals with or scheduled to receive a prosthetic heart valve(s), accidental injury to natural teeth including their replacement (limited to the cost of bridgework of the replacement of teeth injured in an accident unless teeth implants are medically necessary) and the removal of impacted wisdom teeth. (The dental "accident" must be caused by some external force, like a car accident, not by some normal act of mastication, or grinding of teeth while sleeping, or any other naturally occurring circumstance and must have occurred during a period of TennCare eligibility and within twelve (12) months from the date service is requested.)</p>
<p>Vision Services</p>	<p>Age 21 and older: Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of refractive state), will be covered. Routine, periodic assessment, evaluation, or screening of normal eyes and examinations for the purpose of prescribing, fitting or changing eyeglass and/or contact lenses will not be covered.</p> <p>Under age 21: Annual eye exam is covered, however, eyeglasses and contact lenses are not covered.</p>
<p>Home Health Care</p>	<p>As medically necessary, all home health care as delivered by a licensed Home Health Agency, as defined by 42 CFR 440.70, limited to 125 visits per enrollee per calendar year (January – December).</p> <p>A home health visit includes any of the following: Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Pathology, and Home Health Aide. Full-time nursing services are not covered.</p>

<p>Pharmacy Services (obtained directly from an ambulatory retail pharmacy setting, outpatient hospital pharmacy, mail order pharmacy or those administered to a long-term care facility resident (nursing facility))</p>	<p>As medically necessary. Certain drugs (known as DESI, LTE, or IRS drugs) are excluded from coverage.</p>
<p>Durable Medical Equipment</p>	<p>Durable Medical Equipment (DME) refers to equipment, recognized as such by Medicare Part B, that meets all of the following criteria:</p> <ul style="list-style-type: none"> • It can stand repeated use • It is primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience • It is usually not useful to a person in the absence of sickness or injury • It is appropriate for home use • It is related to the patient's physical disorder • The equipment must be used in the beneficiary's home, that is, his/her own home, a relative's home, a home for the aged or other type of institution. An institution is not considered a beneficiary's or member's home if it meets the definition of a hospital or skilled facility. <p>DME may be covered if it is determined to be Medically Necessary and appropriate for the enrollee's condition. The following guidelines and documentation requirements apply to DME whether the equipment is to be purchased or rented:</p> <ul style="list-style-type: none"> • The enrollee's diagnosis should substantiate the need and use of the equipment in the medical record; • Documentation of the enrollee's capability to be trained in the proper use of the equipment; • Rental equipment is generally considered equipment that requires frequent and substantial servicing and maintenance and/or estimated period of use is finite; • Certain rented DME equipment is purchased after the equipment has been rented for a period to be determined by the MCOs. • Documentation of customized equipment should specify the need for the custom equipment versus standard equipment; • Reimbursement may be determined for a more cost-effective alternative if Medical Necessity and appropriateness for the equipment is not demonstrated in the documentation submitted for review; • Contractor may require prior authorization for orthotics over a certain value.

Prior authorization may be required by the MCO to purchase equipment costing more than an amount set by the MCO and approved by TennCare. Items which are investigational or experimental in nature are not covered.

Items not covered include but are not limited to:

Bathtub Equipment and Supplies:

- Bed Bath
- Century Bed Bath
- Eaton E-Z Bath
- Nolan Bath Chair
- Sauna Bath
- Sitz Bath

Beds/Bed Equipment:

- Adjust-A-Bed
- Air Fluidized Bed, Powered Air Flotation Bed, Bead Bed (Clinitron)
- Bed Board
- Bed- Lounge (i.e., Ease-o-matic, Electra-Rest)
- Lounge Bed
- Ortho-Prone Bed
- Oscillating Bed
- Springbase Bed
- Overbed Table
- Vasculating Bed

Cushions, Pads and Mattresses:

- Aquamatic K Pad
- Elbow Protector
- Heat and Massage Foam Cushion Pad
- Heating Pad
- Heel Protector
- Lamb's Wool Pad
- Steam Pack

Environmental Control Items:

- Air Cleaner
- Air Conditioner
- Dehumidifier
- Electric Air Cleaner
- Electrostatic Machine
- Environmental Control Equipment
- Heater, Portable
- Humidifier (Central or Room)
- Micronaire Environmental
- Pollen Extractor
- Portable Room Heaters

Exercise Equipment:

- All exercise equipment, including, but not limited to:
 - Exercise Equipment
 - Exercycle (including cardiac use)
 - Functional Electrical Stimulation
 - Gravity Guidance Inversion Boots
 - Gravitronic Traction Device
 - Moore Wheel
 - Parallel Bars
 - Pulse Tachometer
 - Restorators
 - Tilt Table
 - Training Balls
 - Treadmill Exercisor
 - Weighted Quad Boot

Lifts:

- All Lifts, including, but not limited to:
 - Automobile/ Van Lift
 - Burke Bed Elevator
 - Cheney Safety Bath Lift
 - Electric Powered Recliner and Elevating Seat
 - Elevator
 - Patient Lifts Requiring Home Modification (i.e., ceiling tracks)
 - Stairglide
 - Wheel-O-Vator

Lights:

- Lamp, Heating
- Lamp, Ultraviolet

Nerve Stimulators:

- Dorsal Column Stimulator
- Functional Electrical Stimulation (FES)
- Neuro Muscular Stimulator

Respiratory Aids and Supplies (due to the heavy maintenance requirements and serious cost, equipment and respirators should be rented rather than bought):

- IPV (Intrapulmonary Percussive Ventilator) "Cough-o-lator"
- Preset oxygen system (flow rate not adjustable)
- Spirometer
- Vaporizer

Self-Help Equipment:

- All Self-Help Equipment, including, but not limited to:
 - Automobile Control
 - Automobile Lift
 - Safety Grab Bars
 - Stand Aid

- Standing Table

Speech Device:

- All Speech Devices, including, but not limited to:
 - Phone Mirror Handivoice
 - Speech Teaching Machine
 - Augmentative Communication Devices
 - Computers/Computer Equipment
 - Speech Software

Supports:

- Cervical Pillow
- Floor Stander
- Orthotrac Pneumatic Vest

Toilet Equipment:

- Toilet Trainer

Wheelchairs:

- Amigo Motorized Wheelchair
- Rollabout Chair with casters over 5" in diameter
- Scooters
- Standing Wheelchair

Whirlpools:

- Action Bath Hydro Massage
- Aero Massage
- Aqua Whirl
- Aquasage Pump
- Hand-D-Jet
- Jacuzzi
- Turbojet
- Whirlpool Bath Equipment
- Whirlpool Pump

Miscellaneous:

- Car Seats
- Chair, Ortho-Prone
- Cold Therapy Devices
- Ear Plugs, except for children with tympanostomy tubes ordered by an ENT doctor
- Flash Switches (for toys)
- Obturators
- Paraffin Bath
- Stethoscope
- Sphygmomanometer (Blood Pressure Cuff)
- Telephone Alert System
- Telephone Arm
- Home modifications, including, but not limited to:
 - Ramps

	<ul style="list-style-type: none"> • Decks • Swimming Pools • Fences • Plexiglass • Enlarged Doorways • Room Expansions
<p>Medical Supplies</p>	<p>Covered medical supplies are those supplies that are deemed medically necessary and appropriate and are prescribed for use in the diagnosis and treatment of medical conditions. Medically necessary medical supplies not included as part of institutional services shall be covered only when provided by or through a licensed home health agency, by or through a licensed medical vendor supplier, or by or through a licensed pharmacist.</p> <p>Examples of medical supplies that may be covered include, but are not limited to:</p> <ul style="list-style-type: none"> • Diabetic supplies such as glucometer test strips; <p>Exclusions: Medical supplies that can be obtained without a prescription are considered to be over the counter and are excluded (except for diabetic supplies). Examples include but are not limited to: band-aids, cotton balls, rubbing alcohol, peroxide, dressing material for home use, antiseptics, medicated creams and ointments, Q-tips and eyewash. Supplies used in the home setting or otherwise for self-use which can be obtained without a prescription.</p> <p>Medical supplies may not be prescribed primarily to provide comfort or convenience. Items, which are investigational or experimental in nature, are not covered. Examples of medical supplies that are not covered include, but are not limited to, over-the-counter orthotics, food supplements, vitamins and diapers/liners/underpads.</p> <p>Medical supplies require a written prescription by the recipient's attending physician.</p>
<p>Emergency Air And Ground Ambulance Transportation</p>	<p>As medically necessary.</p>
<p>Community Health Services</p>	<p>As medically necessary.</p>
<p>Renal Dialysis Services</p>	<p>As medically necessary, for the first 90 days prior to being covered by Medicare.</p>
<p>Speech Therapy</p>	<p>Covered as medically necessary, when provided by a Licensed Speech Therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. Limited to the 60-day period from the date therapy begins for any one condition</p>

Occupational Therapy	Covered as medically necessary, when provided by a Licensed Occupational Therapist, to restore, improve, or stabilize impaired functions. Limited to the 60-day period from the date therapy begins for any one condition.
Physical Therapy	Covered as medically necessary, when provided by a Licensed Physical Therapist, to restore, improve, or stabilize impaired functions. Limited to the 60-day period from the date therapy begins for any one condition.
Organ Transplant And Donor Organ Procurement	All medically necessary and non-investigational/non-experimental organ transplants are covered for beneficiaries who have been enrolled in TennCare for a minimum of six (6) consecutive months. These include, but may not be limited to: Bone marrow/Stem cell Cornea Heart Heart/Lung Kidney Kidney/Pancreas Liver Lung Pancreas Small bowel/Multi-visceral
Reconstructive Breast Surgery	Covered in accordance with TCA 56-7-2507 which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy, as well as surgical procedures on the non-diseased breast deemed necessary to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast to establish symmetry with the diseased breast will only be covered if the surgical procedure performed on a non-diseased breast occurs within five (5) years of the date the reconstructive breast surgery was performed on a diseased breast.
Bariatric Surgery, including, but not limited to, Gastric Stapling, Intestinal Bypass Surgery, and Banding	NOT COVERED
EPSDT Services	NOT COVERED
Non-Emergency Transportation	NOT COVERED
Private Duty Nursing	NOT COVERED
Chiropractic Services	NOT COVERED
Sitter	NOT COVERED
Convalescent Care	NOT COVERED

18. Effective January 1, 2003, Section 2-3.2 shall be deleted in its entirety and replaced by a new Section 2-3.2 which shall read as follows:

2-3.2 Medical Necessity

The determination of medical necessity shall be made on a case by case basis. The CONTRACTOR shall not employ, and shall not permit others acting on their behalf to employ utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each TennCare enrollee and his/her medical history. The CONTRACTOR shall have the ability to place tentative limits on a service; however, such limits shall be exceeded when medically necessary based on a patient's individual characteristics. Any procedures used to determine medical necessity shall be consistent with the following definition:

Services or supplies provided by an institution, physician, or other provider that are required to identify or treat a TennCare enrollee's illness, disease, or injury and which are:

- i. Consistent with the symptoms or diagnosis and treatment of the enrollee's illness, disease, ailment or injury; and
- ii. Appropriate with regard to standards of good medical practice; and
- iii. Not solely for the convenience of an enrollee, physician, institution or other provider; and
- iv. The most appropriate supply or level of services which can safely be provided to the enrollee. When applied to the care of an inpatient, it further means that services for the enrollee's medical symptoms or condition require that the services cannot be safely provided to the enrollee as an outpatient; and
- v. When applied to TennCare Medicaid enrollees under 21 years of age, services shall be provided in accordance with EPSDT requirements including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.

19. The first paragraph of Section 2-3.3 shall be deleted in its entirety and replaced by a new first paragraph which shall read as follows:

The following preventive medical services (identified by applicable CPT procedure codes and ADA procedure codes) shall only be covered in accordance with Section 2-3.1 of this Agreement and subject to any limitations described herein, within the scope of standard medical practice, and shall be exempt from any cost sharing responsibilities as described in Section 2-4.10 of this Agreement. In the event that the CPT codes listed below should be revised, consolidated, separated into individual parts, or replaced in part or in whole by new CPT codes, the services represented by the CPT codes listed below shall remain covered services. Vision services, hearing services, and laboratory services not specifically listed herein, which are required pursuant to the Medicaid Early Periodic Screening, Diagnosis and Treatment (EPSDT) program for persons eligible for EPSDT under the TennCare Program under age 21, shall be provided in accordance with the latest "American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care" periodicity schedule for such services. Dental services which are required pursuant to the Medicaid Early Periodic Screening, Diagnosis and Treatment (EPSDT) program for persons under age 21, shall be provided in accordance with the latest periodicity schedule set forth by the American Academy of Pediatric Dentistry and all components of the screens must be consistent with the latest recommendations

by the American Academy of Pediatric Dentistry. It is the responsibility of the MCO to educate providers as to the importance and necessity of documenting all of the components of the screen, and of using the appropriate codes as directed by TENNCARE to the MCOs. It is also the responsibility of the MCO to communicate this data to TENNCARE as directed.

20. Section 2-3.4 shall be deleted in its entirety and replaced by a new Section 2-3.4 which shall read as follows:

2-3.4 Dental Services

Effective October 1, 2002 the TennCare Dental Benefits Manager shall assume responsibility for the provision and payment of dental benefits. However, the provision of transportation to and from said services as well as the medical and anesthesia services not provided by a dentist or in a dentist's office related to the dental service shall remain the responsibility of the CONTRACTOR. The CONTRACTOR shall also agree to coordinate dental and medical services in accordance with the following provisions.

The dental benefits manager shall be responsible for: (1) authorizing dental services for which they have the responsibility to pay; and (2) arranging services to be provided, when appropriate, with providers that are contracted in the CONTRACTOR's plan. The CONTRACTOR shall be responsible for authorizing said services that require transportation, anesthesia not provided by a dentist or in a dentist's office, and/or medical services related to the dental service; however, the CONTRACTOR may waive authorization of said services based on authorization of the dental services by the dental benefits manager.

2-3.4.1 Services And Responsibilities

Coordination of dental services, at a minimum, include:

- Means for referral which assures immediate access for emergency care and a provision of urgent and routine care according to TennCare guidelines;
- Means for the transfer of information (to include items before and after the visit);
- Maintenance of confidentiality; and
- Cooperation with the DBM regarding training activities provided by the DBM.

2-3.4.2 Operating Principles

Coordinating the delivery of dental services to TennCare members is the primary responsibility of the DBM. To ensure such coordination, the DBM shall identify a staff member to serve as lead for coordination of services with each MCO and shall notify the respective MCOs, and the Bureau of TennCare of the name, title, telephone number and other means of communicating with that coordinator. Each MCO shall be responsible for communicating the DBM provider services and/or claim coordinator contact information to all of its providers. With respect to specific member services, resolution of problems shall be carried out between the MCO coordinator and the DBM coordinator. Should systemic issues arise, the MCO and the DBM agree to meet and resolve these issues. In the event that such issues cannot be resolved, the MCO and the DBM shall meet with TENNCARE to reach final resolution of matters involved. Final resolution of system issues shall occur within 90 days from referral to TENNCARE.

- 2-3.4.2.1 Resolution of Requests for Authorization. The MCO agrees and recognizes that the DBM shall agree through its contractual arrangement

with the State, that any dispute concerning which party should respond to a request for prior authorization shall not cause a denial, delay, reduction, termination or suspension of any appropriate service to a TennCare member. DBM and MCO agree that Care Coordinators will, in addition to their responsibilities for care coordination, deal with issues related to requests for authorization which require coordination between DBM and MCO. The DBM and MCO shall provide the other party and TENNCARE with a list of its Care Coordinators and telephone number(s) at which each Care Coordinator may be contacted. When either party receives a request for authorization from a provider for a member and the party believes care is the responsibility of the other party, the Care Coordinator for that party will contact the respective Care Coordinator of the other party by the next business day after receiving the request for prior authorization and communicate to the enrollee or enrollee's provider for routine requests which shall be made within 21 days or less of the provider's request for prior authorization and immediately after receiving the request for prior authorization for urgent requests. The DBM and MCO will establish a coordination committee to address all issues of care coordination. The committee will review disputes regarding clinical care and provide a clinical resolution to the dispute, subject to the terms of this Agreement. The parties will attempt in good faith to resolve any dispute and communicate the decision to the provider requesting authorization of a service. In the event the parties cannot agree within 15 days of the provider's request for prior authorization, the party who first received the request from the provider will be responsible for authorization and payment to their contracted provider within the time frames designated by the Bureau of TennCare. Both parties are responsible for enforcing hold harmless protection for the member. The parties agree that any response to a request for authorization shall not exceed 21 days and shall comply with the Grier Revised Consent Decree.

2-3.4.2.2

Claim Resolution Authorization. The MCO agrees and recognizes that the DBM shall agree through its contractual arrangement with the State, to designate one or more Claim Coordinators to deal with issues related to claims and payment issues that require coordination between DBM and MCO (parties). The DBM and MCO shall provide the other party, and TennCare with a list of its Claim Coordinators and telephone number(s) at which each Claim Coordinator may be contacted.

When either party receives a disputed claim for payment from a provider for a member and the party believes care is the responsibility of the other party, the Claims Coordinator for that party will contact the respective Claims Coordinator of the other party within four (4) business days of receiving such claim for payment. If the Claims Coordinators are unable to reach agreement on which party is responsible for payment of the claim, the claim shall be referred to the Claims Coordination Committee for review.

The DBM and MCO will establish a Claim Coordination Committee made up of Claims Coordinators and other representatives, as needed, from each party. The number of members serving on the Claim

Coordination Committee shall be determined by the mutual agreement of the parties from time to time during the term of this Agreement, or, if the parties fail to agree within ten (10) calendar days of the execution of this Agreement, the Claim Coordination Committee shall consist of two (2) representatives of each party. The Claim Coordination Committee shall review any disputes and negotiate responsibility among the parties. Unless otherwise agreed, such meeting shall take place within ten (10) calendar days of receipt of the initial disputed claim or request from the provider. If resolution of the claim results in the party who assumed responsibility for authorization and payment having no liability, the other party will reimburse and abide by the prior decisions of that party. Reimbursement will be made within ten (10) business days of the Claim Coordination Committee's decision.

If the Claim Coordination Committee cannot reach an agreement as to the proper division of financial responsibility within ten (10) business days of the initial referral to the Claim Coordination Committee, said claim shall be referred to the Chief Executive Officers (CEO) or the CEO's designee, of both DBM and MCO for resolution immediately. A meeting shall be held among the Chief Executive Officers or their designee(s), of the parties within ten (10) calendar days after the meeting of the Claims Coordination Committee, unless the parties agree to meet sooner.

If the meeting between the CEOs, or their designee(s), of the DBM and MCO does not successfully resolve the dispute within 10 days, the parties shall, within fourteen (14) days after the meeting among the CEOs or their designee(s), submit a request for resolution of the dispute to the state or the state's designee for a decision on responsibility after the service has been delivered.

The process as described above shall be completed within 30 days of receiving the claim for payment. In the event the parties cannot agree within 30 days of receiving the claim for payment, both parties will be responsible for enforcing hold harmless protection for the member and the party who first received the request or claim from the provider will be responsible for authorization and payment to the provider within the following time frames designated by the Bureau of TennCare: claims must be processed in accordance with the requirements of the MCO's and DBM's respective Agreements with the State of Tennessee. Moreover, the party that first received the request or claim from the provider must also make written request of all requisite documentation for payment and must provide written reasons for any denial.

The Request for Resolution shall contain a concise description of the facts regarding the dispute, the applicable contract provisions, and position of the party making the request. A copy of the Request for Resolution shall also be delivered to the other party. The other party shall then submit a Response to the Request for Resolution within fifteen (15) calendar days of the date of the Request for Resolution. The Response shall contain the same information required of the Request for Resolution. Failure to timely file a Response or obtain an extension from

the state shall be deemed a waiver of any objections to the Request for Resolution.

The state, or its designee, shall make a decision in writing regarding who is responsible for the payment of services within ten (10) days of the receipt of the required information. ("Decision"). The "Decision" may reflect a split payment responsibility that will designate specific proportions to be shared by the MCO and the DBM which shall be determined solely by the State, or its designee based on specific circumstances regarding each individual case. Within five (5) business days of receipt of the Decision, the non-successful party shall reimburse any payments made by the successful party for the services. The non-successful party shall also pay to the state, within thirty (30) calendar days of the Decision, an administrative fee equal to ten percent (10%) of the value of the claims paid, not to exceed one-thousand dollars (\$1000) for each request for resolution. The amount of the CONTRACTOR's payment responsibility shall be contained in the state's Decision. These payments may be made with reservation of rights regarding any such judicial resolution. If a party fails to pay the state for the CONTRACTOR's payment responsibility as described in this section within (30) calendar days of the date of the state's Decision, the state may deduct amounts of the CONTRACTOR's payment responsibility from any current or future amount owed the party.

- 2-3.4.2.3 Denial, Delay, Reduction, Termination or Suspension. The parties agree that any claims payment dispute or request for authorization shall not cause a denial, delay, reduction, termination or suspension of any appropriate services to a TennCare member. In the event there is a claim for emergency services, the party receiving a request for authorization to treat any member shall insure that the member is treated immediately and payment for the claim must be approved or disapproved based on the definition of emergency medical services specified in this Agreement.
- 2-3.4.2.4 Emergencies. Prior authorization shall not be required for emergency services prior to stabilization.
- 2-3.4.2.5 Claims Processing Requirements. All claims must be processed in accordance with the requirements of the MCO's and DBM's respective Agreements with the State of Tennessee.
- 2-3.4.2.6 Appeal of Decision. Appeal of any Decision shall be to a court or commission of competent jurisdiction and shall not constitute a procedure under the Administrative Procedure Act, T.C.A. §4-5-201 et seq. Exhaustion of the above-described process shall be required before filing of any claim or lawsuit on issues covered by this Section.
- 2-3.4.2.7 Duties and Obligations. The existence of any dispute under this Agreement shall in no way affect the duty of the parties to continue to perform their respective obligations, including their obligations established in their respective contracts with the state pending resolution of the dispute under this Section. In accordance with T.C.A. § 56-32-

226(b), a provider may elect to resolve the claims payment dispute through independent review.

2-3.4.2.8 Confidentiality. The MCO agrees and recognizes that the DBM shall agree through its contractual arrangement with the state, to cooperate with the state to develop Confidentiality Guidelines that (1) meet state, federal, and other regulatory requirements; (2) meet the requirements of the professions or facilities providing care and maintaining records; and (3) meet both DBM and MCO standards. These standards will apply to both DBM's and MCO's providers and staff. If either party believes that the standards require updating, or operational changes are needed to enforce the standards, the parties agree to meet and resolve these issues. Such standards shall provide for the exchange of confidential e-mails to ensure the privacy of the members.

The DBM and MCO shall assure all materials and information directly or indirectly identifying any current or former enrollee which is provided to or obtained by or through the MCO's or DBM's performance of this Agreement, whether verbal, written, tape, or otherwise, shall be maintained in accordance with the standards of confidentiality of Title 33, Tennessee Code Annotated, Section 6-21 of this Agreement, Title 42, Part 2, Code of Federal Regulations, and the Health Insurance Portability and Accountability Act of 1996, ("HIPAA") as amended, and, unless required by applicable law, shall not be disclosed except in accordance with those Titles or to the TennCare Bureau, and the Centers for Medicare and Medicaid Service of the United States Department of Health and Human Services, or their designees. Nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form that does not identify any current or former enrollee or potential enrollee.

2-3.4.2.9 Access to Service. The MCO agrees and recognizes that the DBM shall agree through its contractual arrangement with the State, to establish methods of referral which assure immediate access to emergency care and the provision of urgent and routine care in accordance with TennCare guidelines.

21. Section 2-3.5 shall be deleted in its entirety and replaced by a new Section 2-3.5 which shall read as follows:

2-3.5 *Mental Health and Substance Abuse Services*

All mental health related services and substance abuse services, unless otherwise specified in this Section 2-3.5, provided to enrollees shall be the responsibility of Behavioral Health Organizations (BHOs) who have a contractual arrangement with the Tennessee Department of Mental Health and Developmental Disabilities or the State. These services include:

- Psychiatric Inpatient Facility Services;
- Physician Psychiatric Inpatient Services;
- Outpatient Mental Health Services;
- Inpatient and Outpatient Substance Abuse Treatment Services;
- Psychiatric Pharmacy Services and Pharmacy Related Lab Services;

- Transportation to Covered Mental Health Services;
- Mental Health Case Management;
- 24-Hour Residential Treatment;
- Housing/Residential Care;
- Specialized Outpatient and Symptom Management;
- Specialized Crisis Services; and
- Psychiatric Rehabilitation Services.

Effective July 1, 2002, behavioral health related services provided to enrollees by an MCO Primary Care Provider shall not be the responsibility of Behavioral Health Organizations (BHOs). As some MCO Primary Care Providers may appropriately treat or manage an enrollee's behavioral health condition, and in an effort to minimize administrative complexities for those Primary Care Providers (PCPs), the CONTRACTOR shall be responsible for services provided to enrollees by their network PCPs. Accordingly, the CONTRACTOR shall direct its network PCPs to submit claims for covered services with a **primary** behavioral diagnosis code, defined as ICD-9-CM 290.xx – 319.xx (and subsequent revisions thereto), to the CONTRACTOR for payment. The CONTRACTOR agrees to timely process said claims in accordance with Section 2-9.7.

The MCO shall encourage its PCPs, at their discretion, to contact the BHO for consultation on any covered Mental Health and Substance Abuse condition/service. The PCPs shall also be encouraged to refer to the BHO, for coordination of treatment of any covered Mental Health and Substance Abuse condition/service, for any and all of its members in accordance with its contracts with TDMHDD when those services can be provided by Mental Health Professionals.

The carve out of mental health and substance abuse services provided by PCPs from the BHO benefit package shall not relieve the BHO from the responsibility to assist in the coordination of mental health and substance abuse care and medical care of enrollees; nor shall it prohibit PCPs from referring enrollees to a mental health or substance abuse provider in the BHO's network when determined necessary by the PCP.

The CONTRACTOR is responsible for the costs and provision of covered services that are not mental health or substance abuse services, and covered services provided by a network PCP with a primary behavioral health diagnosis code as specified in the preceding paragraph. The carve out of all other mental health and substance abuse services shall not relieve the CONTRACTOR from the responsibility to assist in the coordination of mental health and medical care of enrollees. The MCO and BHO shall assure active coordination between primary health care and mental health/substance abuse care, including case management and continuity of care services. The MCO and BHO shall cooperate with the State's efforts to facilitate delivery of mental health services to the TennCare population and shall agree to abide by the MCO/BHO Coordination Provisions outlined herein for purposes of interfacing with each other and assure coordination of care, case management and continuity of care for purposes of coordinating appropriate health care.

2-3.5.1 Services And Responsibilities

Coordination of physical health care and mental health care shall, at a minimum, include:

- Means for referral which assures immediate access for emergency care and a provision of urgent and routine care according to TennCare guidelines;
- Means for the transfer of information (to include items before and after the visit);

- Maintenance of confidentiality; and
- Cooperation with the BHOs regarding training activities provided by the BHOs.

2-3.5.2 Operating Principles

The CONTRACTOR recognizes that the BHO shall support the MCO and all of its providers in their delivery of behavioral health services to all TennCare members by, but not limited to, providing advice, consultation, and assistance in coordinating the delivery of behavioral health services. Coordinating the delivery of behavioral health services to TennCare members is the primary responsibility of the BHO. To ensure such coordination, the BHO shall identify a staff member to serve as lead for coordination of services with each MCO and shall notify the respective MCOs, TDMHDD, and the Bureau of TennCare of the name, title, telephone number and other means of communicating with that coordinator. Each MCO shall be responsible for communicating the BHO provider services and/or claim coordinator contact information to all of its providers, including PCPs. With respect to specific member services, including transfer of responsibility for services from the PCP to the BHO, resolution of problems shall be carried out between the PCP (or MCO representative) and the BHO coordinator. Should systemic issues arise, the MCO and the BHO agree to meet and resolve these issues. In the event that such issues cannot be resolved, the MCO and the BHO shall meet with TDMHDD and TennCare to reach final resolution of matters involved. Final resolution of system issues shall occur within 90 days from referral to TDMHDD or TennCare.

- 2-3.5.2.1 Resolution of Requests for Authorization for non-PCPs delivering Behavioral Health services. The MCO agrees and recognizes that the BHO shall agree through its contractual arrangement with the Tennessee Department of Mental Health and Developmental Disabilities or the State, that any dispute concerning which party should respond to a request for prior authorization shall not cause a denial, delay, reduction, termination or suspension of any appropriate service to a TennCare member. BHO and MCO agree that Care Coordinators will, in addition to their responsibilities for care coordination, deal with issues related to requests for authorization which require coordination between BHO and MCO. The BHO and MCO shall provide the other party and TENNCARE with a list of its Care Coordinators and telephone number(s) at which each Care Coordinator may be contacted. When either party receives a request for authorization from a provider for a member and the party believes care is the responsibility of the other party, the Care Coordinator for that party will contact the respective Care Coordinator of the other party by the next business day after receiving the request for prior authorization and communicate to the enrollee or enrollee's provider for routine requests which shall be made within 21 days or less of the provider's request for prior authorization and immediately after receiving the request for prior authorization for urgent requests. The BHO and MCO will establish a coordination committee to address all issues of care coordination. The committee will review disputes regarding clinical care and provide a clinical resolution to the dispute, subject to the terms of this Agreement. The parties will attempt in good faith to resolve any dispute and communicate the decision to the

provider requesting authorization of a service. In the event the parties cannot agree within 15 days of the provider's request for prior authorization, the party who first received the request from the provider will be responsible for authorization and payment to their contracted provider within the time frames designated by the Bureau of TennCare. Both parties are responsible for enforcing hold harmless protection for the member. The parties agree that any response to a request for authorization shall not exceed 21 days and shall comply with the Grier Revised Consent Decree.

2-3.5.2.2

Claim Resolution Authorization for non-PCPs delivering Behavioral Health services. The MCO agrees and recognizes that the BHO shall agree through its contractual arrangement with the Tennessee Department of Mental Health and Developmental Disabilities or the State, to designate one or more Claim Coordinators to deal with issues related to claims and payment issues that require coordination between BHO and MCO (parties). The BHO and MCO shall provide the other party, TDMHDD, and TennCare with a list of its Claim Coordinators and telephone number(s) at which each Claim Coordinator may be contacted.

When either party receives a disputed claim for payment from a provider for a member and the party believes care is the responsibility of the other party, the Claims Coordinator for that party will contact the respective Claims Coordinator of the other party within four (4) business days of receiving such claim for payment. If the Claims Coordinators are unable to reach agreement on which party is responsible for payment of the claim, the claim shall be referred to the Claims Coordination Committee for review.

The BHO and MCO will establish a Claim Coordination Committee made up of Claims Coordinators and other representatives, as needed, from each party. The number of members serving on the Claim Coordination Committee shall be determined by the mutual agreement of the parties from time to time during the term of this Agreement, or, if the parties fail to agree within ten (10) calendar days of the execution of this Agreement, the Claim Coordination Committee shall consist of two (2) representatives of each party. The Claim Coordination Committee shall review any disputes and negotiate responsibility among the parties. Unless otherwise agreed, such meeting shall take place within ten (10) calendar days of receipt of the initial disputed claim or request from the provider. If resolution of the claim results in the party who assumed responsibility for authorization and payment having no liability, the other party will reimburse and abide by the prior decisions of that party. Reimbursement will be made within ten (10) business days of the Claim Coordination Committee's decision.

If the Claim Coordination Committee cannot reach an agreement as to the proper division of financial responsibility within ten (10) business days of the initial referral to the Claim Coordination Committee, said claim shall be referred to the Chief Executive Officers (CEO) or the CEO's designee, of both BHO and MCO for resolution immediately. A meeting shall be held among the Chief Executive Officers or their

designee(s), of the parties within ten (10) calendar days after the meeting of the Claims Coordination Committee, unless the parties agree to meet sooner.

If the meeting between the CEOs, or their designee(s), of the BHO and MCO does not successfully resolve the dispute within 10 days, the parties shall, within fourteen (14) days after the meeting among the CEOs or their designee(s), submit a request for resolution of the dispute to the state or the state's designee for a decision on responsibility after the service has been delivered.

The process as described above shall be completed within 30 days of receiving the claim for payment. In the event the parties cannot agree within 30 days of receiving the claim for payment, both parties will be responsible for enforcing hold harmless protection for the member and the party who first received the request or claim from the provider will be responsible for authorization and payment to the provider within the following time frames designated by the Bureau of TennCare: claims must be processed in accordance with the requirements of the MCO's and BHO's respective Agreements with the State of Tennessee. Moreover, the party that first received the request or claim from the provider must also make written request of all requisite documentation for payment and must provide written reasons for any denial.

The Request for Resolution shall contain a concise description of the facts regarding the dispute, the applicable contract provisions, and position of the party making the request. A copy of the Request for Resolution shall also be delivered to the other party. The other party shall then submit a Response to the Request for Resolution within fifteen (15) calendar days of the date of the Request for Resolution. The Response shall contain the same information required of the Request for Resolution. Failure to timely file a Response or obtain an extension from the state shall be deemed a waiver of any objections to the Request for Resolution.

The state, or its designee, shall make a decision in writing regarding who is responsible for the payment of services within ten (10) days of the receipt of the required information. ("Decision"). The "Decision" may reflect a split payment responsibility that will designate specific proportions to be shared by the MCO and the BHO which shall be determined solely by the State, or its designee based on specific circumstances regarding each individual case. Within five (5) business days of receipt of the Decision, the non-successful party shall reimburse any payments made by the successful party for the services. The non-successful party shall also pay to the state, within thirty (30) calendar days of the Decision, an administrative fee equal to ten percent (10%) of the value of the claims paid, not to exceed one-thousand dollars (\$1000) for each request for resolution. The amount of the CONTRACTOR's payment responsibility shall be contained in the state's Decision. These payments may be made with reservation of rights regarding any such judicial resolution. If a party fails to pay the state for the CONTRACTOR's payment responsibility as described in this section

within (30) calendar days of the date of the state's Decision, the state may deduct amounts of the CONTRACTOR's payment responsibility from any current or future amount owed the party.

- 2-3.5.2.3 Denial, Delay, Reduction, Termination or Suspension. The parties agree that any claims payment dispute or request for authorization shall not cause a denial, delay, reduction, termination or suspension of any appropriate services to a TennCare member. In the event there is a claim for emergency services, the party receiving a request for authorization to treat any member shall insure that the member is treated immediately and payment for the claim must be approved or disapproved based on the definition of emergency medical services specified in this Agreement.
- 2-3.5.2.4 Emergencies. Prior authorization shall not be required for emergency services prior to stabilization.
- 2-3.5.2.5 Claims Processing Requirements. All claims must be processed in accordance with the requirements of the MCOs and BHOs respective Agreements with the State of Tennessee.
- 2-3.5.2.6 Appeal of Decision. Appeal of any Decision shall be to a court or commission of competent jurisdiction and shall not constitute a procedure under the Administrative Procedure Act, T.C.A. §4-5-201 et seq. Exhaustion of the above-described process shall be required before filing of any claim or lawsuit on issues covered by this Section.
- 2-3.5.2.7 Duties and Obligations. The existence of any dispute under this Agreement shall in no way affect the duty of the parties to continue to perform their respective obligations, including their obligations established in their respective contracts with the state pending resolution of the dispute under this Section. In accordance with T.C.A. § 56-32-226(b), a provider may elect to resolve the claims payment dispute through independent review.
- 2-3.5.2.8 Confidentiality. The MCO agrees and recognizes that the BHO shall agree through its contractual arrangement with the Tennessee Department of Mental Health and Developmental Disabilities or the State, to cooperate with the state to develop Confidentiality Guidelines that (1) meet state, federal, and other regulatory requirements; (2) meet the requirements of the professions or facilities providing care and maintaining records; and (3) meet both BHO and MCO standards. These standards will apply to both BHO's and MCO's providers and staff. If either party believes that the standards require updating, or operational changes are needed to enforce the standards, the parties agree to meet and resolve these issues. Such standards shall provide for the exchange of confidential e-mails to ensure the privacy of the members.

The BHO and MCO shall assure all materials and information directly or indirectly identifying any current or former enrollee which is provided to or obtained by or through the MCO's or BHO's performance of this Agreement, whether verbal, written, tape, or otherwise, shall be maintained in accordance with the standards of confidentiality of Title

33, Tennessee Code Annotated, Section 4-21 of this Agreement, Title 42, Part 2, Code of Federal Regulations, and the Health Insurance Portability and Accountability Act of 1996, ("HIPAA") as amended, and, unless required by applicable law, shall not be disclosed except in accordance with those Titles or to TDMHDD, the TennCare Bureau, and the Centers for Medicare and Medicaid Service of the United States Department of Health and Human Services, or their designees. Nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form that does not identify any current or former enrollee or potential enrollee.

2-3.5.2.9 Access to Service. The MCO agrees and recognizes that the BHO shall agree through its contractual arrangement with the Tennessee Department of Mental Health and Developmental Disabilities or the State, to establish methods of referral which assure immediate access to emergency care and the provision of urgent and routine care in accordance with TennCare guidelines.

22. Section 2-3.8.a shall be deleted and replaced in its entirety so that the amended Section 2-3.8.a shall read as follows:
- a. The CONTRACTOR is responsible for coordinating TennCare-covered benefits with benefits offered by other insurance, including Medicare, which the enrollee may have. For Medicaid eligibles, such coordination must insure that TennCare-covered services are delivered without charge to the enrollee except for applicable pharmacy cost share responsibilities in accordance with TennCare waiver provisions and the TennCare rules and regulations.
23. Section 2-3.12 shall be amended by deleting the reference to "Health Care Financing Administration" and replacing it with the reference to "Centers for Medicare & Medicaid Services" and adding a new third paragraph in between the existing second and third paragraphs so that the amended Section 2-3.12 shall read as follows:

2-3.12 Coverage of Organ Transplants

The CONTRACTOR shall cover at a minimum the following transplants: Renal, Heart, Liver, Corneal and Bone Marrow, when medically necessary and consistent with the accepted mode of treatment for which the transplant procedure is performed. The CONTRACTOR shall not cover transplants or procedures, which are not medically necessary or performed for a purpose inconsistent with acceptable modes of treatment. Besides the minimally required transplants, the CONTRACTOR may cover other transplants that are not considered investigational or experimental by the National Institutes of Health and the Tennessee Department of Finance and Administration, if approved by TennCare. For purposes of this Section, investigational or experimental shall mean those transplants and/or procedures which are not considered medically necessary and which have not been approved by the Centers for Medicare & Medicaid Services and published in the Federal Register. Questions as to whether a particular transplant and/or procedure is to be covered shall be directed to the Office of the Medical Director, Bureau of TENNCARE.

Exceptions to the above list of transplants must be made for other non-investigational/non-experimental transplants if the transplant and/or procedure is found to be medically necessary, performed within the accepted mode of treatment for which it is intended, and is found to be cost effective as determined by the CONTRACTOR.

Effective January 1, 2003, coverage of organ transplants shall be limited to those organ transplants also covered by Medicare for TennCare Medicaid adults ages twenty-one (21) and over. Organ Transplants for TennCare Medicaid eligible enrollees under the age of twenty-one (21) shall be covered as medically necessary in accordance with EPSDT requirements. As described in Section 2-3.a.1(c), coverage of organ transplants for TennCare Standard enrollees (adults and children) shall only be available for beneficiaries who have been enrolled in TennCare for a minimum of six (6) consecutive months.

The CONTRACTOR shall establish administrative procedures regarding the necessity of prior approval before a transplant procedure is performed. The CONTRACTOR shall also establish its own administrative procedures regarding the coverage of transplant procedures performed outside the CONTRACTOR's service area as well as transplant procedures performed out-of-state. These administrative procedures shall be submitted to TennCare for review and approval prior to use.

Section 1862 of the Social Security Act requires Medicare beneficiaries to have transplants performed in Medicare certified centers. In accordance with this policy, the CONTRACTOR and Medicare/TennCare dually eligible enrollees shall be required to adhere to these requirements.

24. Section 2-3 shall be amended by adding a new Section 2-3.16 "EPSDT Requirements" which shall read as follows:

2-3.16 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Requirements

The CONTRACTOR must have written policies and procedures for an EPSDT program that includes coordinating services with other TennCare providers, providing all medically necessary Title XIX EPSDT services to all eligible individuals under the age of twenty-one (21) regardless of whether the service is included in the Medicaid State Plan as well as outreach and education.

The CONTRACTOR shall provide EPSDT services to enrollees under age 21 who are eligible for EPSDT in the TennCare Program in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989. EPSDT Services (Early and Periodic Screening, Diagnosis and Treatment of Individuals under age 21) means early and periodic screening, diagnosis and treatment of enrollees under age 21 made pursuant to 42 U.S.C. Sections 1396a(a)(43), 1396d(a) and (r) and 42 CFR Part 441, Subpart B to ascertain children's individual (or individualized/or on an individual basis) physical and mental defects, and providing treatment to correct or ameliorate, or prevent from worsening defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered. The CONTRACTOR shall be responsible for the provision of all related services except for behavioral health services that are carved out as a separate arrangement from this Agreement and Dental services at such time as they are removed from the responsibilities described in this Agreement. Effective upon receipt of written notification from TENNCARE, the CONTRACTOR is not required to provide services in accordance with EPSDT requirements to TennCare Standard enrollees under the age of 21.

By the end of October, 2002, TENNCARE shall identify a committee to begin analyzing the possibility of establishing an EPSDT transition file process.

- 2-3.16.1 In accordance with TennCare requirements and pursuant to 42 USC §1396d(r), Early and periodic screening, diagnostic, and treatment (EPSDT) services shall at a minimum include:

- 2-3.16.1.1. Screening services provided at intervals:
 - 1. which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care
 - 2. indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions and

- 2-13.16.1.2. Services which, at a minimum, include
 - 1. comprehensive health and developmental history (including assessment of both physical and mental health development and dietary practices);
 - 2. a comprehensive unclothed physical exam (the child's growth shall be compared against that considered normal for the child's age);
 - 3. appropriate immunizations (according to the schedule set out in 42 USC 1396s(c)(2)(B)(i) for pediatric vaccines) according to age and health history
 - 4. laboratory tests (including lead blood level assessment appropriate for age and risk factors)
 - 5. health education (including anticipatory guidance)
 - 6. Vision services
 - 1. which are provided at intervals which meet reasonable standards of medical practice, as determined by the state after consultation with recognized medical organizations involved in child health care and
 - 2. which at a minimum include diagnosis and treatment for defects in vision, including eyeglasses
 - 7. Dental services which are provided
 - 1. at intervals which meet reasonable standards of dental practice as determined by the state after consultation with recognized dental organizations involved in child health care and
 - 2. at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition
 - 3. and which shall at a minimum include relief of pain and infections, restoration of teeth and maintenance of dental health

8. Hearing services which are provided
 1. at intervals which meet reasonable standards of medical practice as determined by the state after consultation with recognized medical organizations involved in child health care and
 2. at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition and
 3. Which shall at a minimum include diagnosis and treatment for defects in hearing, including hearing aids.

9. Transportation assistance for a child includes related travel expenses, cost of meals, and lodging in route to and from care, and the cost of an attendant to accompany a child if necessary. Blanket restrictions may not be imposed when determining coverage for transportation services. Each determination shall be based on individualized circumstances for each case by the CONTRACTOR and/or the transportation vendor. Each request for transportation services is to be reviewed individually and documented by the CONTRACTOR and/or the transportation vendor.

The requirement to provide the cost of meals shall not be interpreted to mean that an enrollee and/or an attendant can request meals while in transport to and from care. Rather, this provision is intended for use when an enrollee has to be transported to a major health facility for services and care cannot be completed in one day thereby requiring an overnight stay.

The CONTRACTOR shall offer transportation and scheduling assistance to all children under age 21 referred for an assessment who do not have access to transportation. This may be accomplished through various means of communication to enrollees, including but not limited to, member handbooks, EPSDT outreach notifications, etc.

An EPSDT enrollee may be considered for transportation if such enrollee has written permission from the treating physician and custodial parent(s). Circumstances that may permit the CONTRACTOR and/or its transportation vendor to refuse the transportation request would be as follows:

- (i) The EPSDT enrollee is under the age of eighteen (18) and does not have an attendant.
- (ii) The EPSDT enrollee has an attendant, but the attendant is not a parent or legal guardian and cannot legally sign for the enrollee to receive medical care, i.e., the EPSDT enrollee may be a foster or stepchild. Some foster or stepparents do not have legal authority to sign for medical care for foster or step children. The CONTRACTOR and transportation vendors must be aware of this and must ask these questions when scheduling transport.
- (iii) The enrollee or attendant according to a reasonable person's standards has to be noticeably indisposed [disorderly conduct, intoxicated, armed (firearms), possession of illegal drugs, knives

and/or other weapons], and in any other condition that may affect the safety of the driver or persons being transported.

10. Follow up for elevated blood lead levels in children must be carried out in accordance with the State Medicaid Manual, Part 5 (http://www.hcfa.gov/pubforms/pub45/pub_45.htm). The Manual currently says that children with blood lead levels equal to or greater than 10ug/dL should be followed according to CDC guidelines. These guidelines include follow up blood tests and investigations to determine the source of lead, when indicated.

In accordance with the State Medicaid Directors' letter issued by CMS (formerly HCFA) on October 22, 1999, MCOs are responsible for "any follow up service within the scope of the federal Medicaid statute, including diagnostic or treatment services determined to be medically necessary" when elevated blood lead levels are identified in children. "Such services would include both case management services and the one-time investigation to determine the source of lead."

The MCO is responsible for the primary environmental lead investigation for children when elevated blood levels suggest a need for such an investigation. This investigation, which is commonly called a "lead inspection," involves the use of x-ray fluorescence (XRF) machines in the home which have the ability to identify lead-based paint.

If the lead inspection does not reveal the presence of lead paint in the home, there may be a need for other testing, such as "risk assessments" involving water and soil sampling or inspections of sites other than the primary residence if the child spends a substantial amount of time in another location. The MCO is not responsible for either the "risk assessments" or the lead inspection at the secondary site. The Department of Health should be contacted when these services are indicated. TDH has a federal grant which can be used to purchase such services when either or both are deemed necessary by health department staff, as long as funds are available. The assessments are done by certified inspectors in the Department of Environment and Conservation.

MCO reimbursement for the primary environmental investigations is limited to the items specified in Part 5 of the State Medicaid Manual. These items include the health professional's time and activities during the on-site investigation of the child's primary residence. They do not include testing of environmental substances such as water, paint, or soil.

11. Such other necessary health care, diagnostic services, treatment, and other measures described in 42 USC 1396d(a) to correct, ameliorate or prevent from worsening defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.

2-3.16.2 42 CFR 441.56(b) defines "screening" as "periodic comprehensive child health assessments" meaning "regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of

infants, children, and youth.” At a minimum, screenings must include, but are not limited to:

1. Comprehensive health and developmental history;
2. Comprehensive unclothed physical examination;
3. Appropriate Immunizations;
4. Appropriate vision and hearing testing;
5. Appropriate laboratory tests; and
6. Dental screening services furnished by direct referral to a dentist for children no later than 3 years of age and should be referred earlier as needed (as early as 6 to 12 months in accordance with the American Academy of Pediatric Dentistry (AAPD) guidelines) and as otherwise appropriate; and
7. Health Education.

These screening services must be provided in accordance with “reasonable standards of medical and dental practice” as determined by the State. The State has determined that “reasonable standards of medical and dental practice” are those standards set forth in the American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care for medical practice and American Academy of Pediatric Dentistry (AAPD) guidelines for dental practice. Pursuant to Section 2-3.a.3, “screens shall be in accordance with the periodicity schedule set forth in the latest ‘American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care’ and all components of the screens must be consistent with the latest ‘American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care’ and the American Academy of Pediatric Dentistry (AAPD) guidelines.

2-3.16.3 Should screenings indicate a need, the following services must be provided, even if the services are not included in the State plan:

1. Diagnosis of and treatment for defects in vision and hearing, including eyeglasses and hearing aids;
2. Dental care, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health; and
3. Appropriate immunizations.
4. Such other necessary health care, diagnostic services, treatment, and other measures described in 42 USC 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.

2-3.16.4 The CONTRACTOR shall comply with all requirements described in this Agreement regarding EPSDT, including but not limited to:

1. Screening rate requirements/Local Health Department Contracts as described in Sections 2-4.9.2 and 2-9.6.3; and
2. Reporting, including but not limited to, Performance Indicators and Focused Studies as described in Sections 2-10.14, Attachment I and Attachment II; and
3. Performance Guarantees as described in Section 6-27; and
4. The “EPSDT Screening Guidelines” and “Scope of Covered Benefits under EPSDT” as described in Attachments VIII and IX of this Agreement.

- 2-3.16.5 The CONTRACTOR shall have policies and procedures in place, approved by TENNCARE, to require providers to refer enrollees for other necessary health care, diagnostic services, treatment and other measures to correct, ameliorate, or prevent from worsening defects, and mental illnesses and conditions discovered by the screening service, regardless of whether the required services is covered by the enrollee's BHO or MCO, and to document said referrals in the enrollee's medical record.
- 2-3.16.6 The CONTRACTOR shall direct its network providers to notify the MCO in the event a screening reveals the need for other health care and the provider is unable to make an appropriate referral for those services. Upon notification of the failed referral, the CONTRACTOR shall secure an appropriate referral and contact the enrollee to offer scheduling assistance and transportation for enrollees lacking access to transportation. If the needed health care is a BHO benefit, the CONTRACTOR shall contact the enrollee's BHO and inform them of the need to contact the enrollee to secure an appropriate referral and offer scheduling assistance and transportation. The CONTRACTOR shall maintain documentation of said contacts. In the event of a dispute regarding the organization responsible for the provision of the services, the CONTRACTOR shall adhere to the requirements specified in Section 2-3.5.
- 2-3.16.7 The CONTRACTOR shall be responsible for various outreach activities and for informing enrollees assigned to its plan who are under the age of 21, or their parent or guardian, of the availability of early and periodic screening, diagnostic, and treatment services. All Enrollee material shall be submitted to TENNCARE for approval prior to distribution and shall be made available in accordance with the requirements specified in Section 2-6. In order to comply with this requirement, the CONTRACTOR shall, at a minimum, adhere to the following:
1. The CONTRACTOR must have a process in place to distribute to each member a minimum of six (6) "outreach contacts" a year from the MCO with information about EPSDT. The "outreach contacts" include: 1 member handbook, 4 newsletters, 1 reminder before a screening is due.
 - a. Information included in the member handbook regarding EPSDT services must sent within thirty (30) days of receipt of notification of enrollment as specified in Section 2-6.2.c.1. Annually thereafter, upon the Enrollee's anniversary date of enrollment, the CONTRACTOR shall send a reminder of EPSDT services. All handbooks must be in accordance with the TennCare Marketing Guidelines and Section 2-6 of this Agreement.
 - b. Each quarterly newsletter, as described in Section 2-6.2.c.2 shall include EPSDT information, including but not limited to, encouragement to obtain screenings and other preventive care services.
 - c. The MCO must have a mechanism for notifying families when EPSDT screens are due. This mechanism must include an offer of transportation and scheduling assistance.
 2. The CONTRACTOR shall have a process for following up with members who do not get their screenings timely. This process for follow up must include provisions for documenting all outreach attempts and must be submitted to TENNCARE for review and approval. Should the CONTRACTOR fail to submit an acceptable process for following up with members who do not get their

screenings timely, the CONTRACTOR shall assure that the member get an additional "outreach contact" each quarter from the MCO. Each of these additional "outreach contacts" will be a different written or oral strategy. The MCO must have a mechanism for maintaining records of efforts made to reach out to children who have missed screening appointments or who have failed to receive regular check-ups. The MCO must make at least one effort each quarter to get the child in for a screening. The efforts, whether written or oral, should be different each quarter. It will not be adequate to simply send the same letter four times.

3. The MCO must have a process for determining if someone eligible for EPSDT has used no services within a year. The MCO must have a process for making two reasonable attempts to re-notify such members about EPSDT. One of these attempts can be a referral to the health department. (These two attempts are in addition to the one attempt per quarter mentioned above.)
 4. The MCO shall require that providers have a process for documenting services declined by a parent or guardian or mature competent child, specifying the particular service was declined. This process must meet all requirements outlined in the State Medicaid Manual, Part 5, Section 5320A, concerning declination of EPSDT services.
 5. The MCO must make and document a minimum of two (2) reasonable attempts to find a family when mail is returned as undeliverable. At least one of these attempts must be oral.
 6. The MCO must make available to families accurate lists of names and phone numbers of contract providers who are currently accepting TennCare as described in Section 4-1.2 of this Agreement.
 7. The MCO must target specific informing activities to pregnant women and families with newborns. Pregnant women must be informed prior to the enrollee's delivery date about the availability of EPSDT for their children, provided that the MCO is informed of the pregnancy, and must be offered EPSDT services for the child when it is born.
 8. Pregnant women who are determined presumptively eligible must receive assistance in making a timely prenatal appointment as soon as the MCO is aware of the presumptive eligibility. For a woman past her first trimester, the appointment should occur within 15 days in accordance with 2-3.15.
- 2-3.16.8 The services listed in the Social Security Act, Section 1905(a), and the entity responsible for providing them under TennCare, are listed below. All services, other than EPSDT screens and interperiodic screens, must be medically necessary in order to qualify for TennCare coverage. Services may be required to be provided by network provider. All services provided by non-participating providers may require prior approval by the MCO.

Services Listed in Social Security Act Section 1905(a)	Responsible Entity in Tennessee	Comments
(1) Inpatient hospital services (other than services in an institution for mental diseases)	MCO	
(2)(A) Outpatient hospital services	MCO	
(2)(B) Rural health clinic services	MCO	MCOs are not required to contract with Rural Health Clinics if the services are available through other providers in their networks.
(2)(C) Federally-qualified health center services	MCO	MCOs are not required to contract with FQHCs if they can demonstrate adequate provider capacity without them.
(3) Other laboratory and X-ray services	MCO, except that the BHO is responsible for laboratory services relating to BHO drugs	
(4)(A) Nursing facility services for individuals age 21 and older		Not applicable for EPSDT
(4)(B) EPSDT services	MCO for physical health services, except as described in Section 2-3.5; BHO for mental health and substance abuse services, except as described in Section 2-3.5; and DBM for dental services	
(4)(C)--Family planning services and supplies	MCO	
(5)(A)--Physicians' services furnished by a physician, whether furnished in the office, the patient's home, a hospital, or a nursing facility	MCO for physical health services, except as described in Section 2-3.5; BHO for mental health and substance abuse services, except as described in Section 2-3.5	

Amendment 1 (continued)

(5)(B)—Medical and surgical services furnished by a dentist	DBM	
(6)—Medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law	MCO for physical health services; BHO for mental health and substance abuse services	See Item (13).
(7)—Home health care services	MCO for physical health services; BHO for mental health and substance abuse services	
(8)—Private duty nursing services	MCO for physical health services; BHO for mental health and substance abuse services	
(9)—Clinic services	MCO for physical health services; BHO for mental health and substance abuse services	
(10)—Dental services	DBM	
(11)—Physical therapy and related services	MCO	
(12)—Prescribed drugs, dentures, and prosthetic devices, and eyeglasses	MCO for physical health services; TennCare for mental health and substance abuse drugs DBM for dentures	

<p>(13) Other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level</p>	<p>MCO for physical health services; BHO for mental health and substance abuse services</p>	<p>The following are considered practitioners of the healing arts in Tennessee law¹:</p> <ul style="list-style-type: none"> • Alcohol and drug abuse counselor • Athletic trainer • Audiologist • Certified acupuncturist • Certified master social worker • Certified nurse practitioner • Certified professional counselor • Certified psychological assistant • Chiropractic physician • Chiropractic therapy assistant • Clinical pastoral therapist • Dentist • Dental assistant • Dental hygienist • Dietitian/nutritionist • Dispensing optician • Electrologist • Emergency medical personnel • First responder • Hearing instrument specialist • Laboratory personnel • Licensed clinical perfusionist • Licensed clinical social worker • Licensed practical nurse • Licensed professional counselor • Marital and family therapist, certified • Marital and family therapist, licensed • Massage therapist • Medical doctor • Medical doctor (special training)
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¹ This list has been provided by the Tennessee Department of Health.

		<ul style="list-style-type: none"> • Midwives and nurse midwives • Nurse aide • Occupational therapist • Occupational therapy assistant • Optometrist • Osteopathic physician • Pharmacist • Physical therapist • Physical therapist assistant • Physician assistant • Podiatrist • Psychological examiner • Psychologist • Registered nurse • Registered certified reflexologist • Respiratory care assistant • Respiratory care technician • Respiratory care therapist • Senior psychological examiner • Speech pathologist • Speech pathology aide • X-ray op in chiropractic physician's office • X-ray op in MD office • X-ray op in osteopathic office • X-ray op in podiatrist's office
(14) Inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases		Not applicable for EPSDT
(15) Services in an intermediate care facility for the mentally retarded	TennCare	
(16) Inpatient psychiatric services for individuals under age 21	BHO	
(17) Services furnished by a nurse-midwife	MCO	The MCOs are not required to contract with nurse-midwives if the services are available through other providers in their networks.

(18) Hospice care	MCO	
(19) Case management services	MCO for physical health services; BHO for mental health and substance abuse services	
(20) Respiratory care services	MCO	
(21) Services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner	MCO	The MCOs are not required to contract with PNP's or CFNP's if the services are available through other providers in their networks.
(22) Home and community care for functionally disabled elderly individuals		Not applicable for EPSDT
(23) Community supported living arrangements services		Not applicable for EPSDT
(24) Personal care services	MCO for physical health services; BHO for mental health and substance abuse services	
(25) Primary care case management services	MCO	
(26) Services furnished under a PACE program		Not applicable for EPSDT
(27) Any other medical care, and any other type of remedial care recognized under State law.	MCO for physical health services; BHO for mental health and substance abuse services	See Item (13).

Note 1: "Targeted case management services," which are listed under section 1915(g)(1), are **not EPSDT services** except to the extent that the definition in section 1915(g)(2) is used with Item (19) above. DCS provides targeted case management services to children in custody and at risk of custody.

Note 2: "Psychiatric residential treatment facility" is not listed in Social Security Act section 1905(a). It is, however, defined in 42 CFR 483.352 as "a facility other than a hospital, that provides psychiatric services, as described in subpart D of part 441 of this chapter, to individuals under age 21, in an inpatient setting." Psychiatric residential treatment facility services are furnished by DCS to children in custody but are otherwise the responsibility of the BHO.

Note 3: "Rehabilitative" services are differentiated from "habilitative" services in federal law. "Rehabilitative" services, which are EPSDT services, are defined in 42 CFR 440.130(d) as services designed "for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level." "Habilitative" services, which are **not EPSDT services**, are defined in section 1915(c)(5) as services designed "to assist individuals in acquiring, retaining, and

improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings.”

Note 4: Certain services are covered under a Home and Community Based Waiver but are **not EPSDT services** because they are not listed in the Social Security Act section 1905(a). These services include habilitation, prevocational, and supported employment services; homemaker services; and respite services. (See section 1915(c)(4).)

Note 5: Certain services are not coverable even under a Home and Community Based Waiver and are **not EPSDT services**. These services include room and board, and special education and related services which are otherwise available through a Local Education Agency. (See section 1915(c)(5).)

25. Section 2-3 shall be amended by adding a new Section 2-3.17 “Immediate Eligibility for Children in DCS Custody” which shall read as follows:

2-3.17 Immediate Eligibility for Children in DCS Custody

Effective January 1, 2002, when a child enters DCS custody, DCS will provide the CONTRACTOR with the child’s information. In order to give children in DCS adequate access to medical services, including EPSDT, until a final determination can be made on their TennCare eligibility, the CONTRACTOR shall accept notification from DCS and adhere to the following requirements to insure that eligibility is provided. Upon receipt of notification from DCS, the CONTRACTOR shall determine whether or not the child is otherwise enrolled in TennCare. If the child is not currently enrolled, the CONTRACTOR shall immediately build a forty-five (45) day TennCare eligibility record effective on the date the child was placed in state custody and identify the child as a child in state custody, or group 1.A enrollee. The CONTRACTOR shall generate a letter that will explain that the child has been given forty-five (45) days of coverage from their custody date, pending a final eligibility determination. The CONTRACTOR is not required to assign a child for whom immediate eligibility has been established to a BPN PCP until TennCare eligibility is confirmed. The CONTRACTOR shall fax the BPN enrollment form and a letter of notification to the DCS Case Manager. The CONTRACTOR’s BPN staff shall work with DCS to obtain an EPSDT visit with a BPN provider within twenty-one (21) days of request but no later than thirty (30) days of enrollment. After twenty-five (25) days of immediate eligibility coverage, the CONTRACTOR shall identify children whose immediate eligibility will end in twenty (20) days to the DCS Program Coordinator of Health Advocacy. The child shall be eligible for the TennCare Medicaid benefit package effective on the date the child was placed in custody through the 45th day of the Immediate Eligibility period or the date of receipt of a TennCare eligibility record, whichever occurs earlier. If the CONTRACTOR receives a TennCare eligibility record prior to the end of the forty-five (45) day eligibility period, the child shall be eligible for benefits in accordance with their TennCare eligibility status effective on the date of receipt of the eligibility record.

In regards to EPSDT reporting, the CONTRACTOR will continue to only report on those children whose TennCare eligibility has appeared on the DCS Tape received from TENNCARE and who are assigned to MCO 11.

26. The title of Section 2-4.1.3 “Emergency Medical Services” shall be deleted and replaced with the title “Availability and Accessibility of Emergency Medical Services”.
27. The first sentence of Section 2-4.5 shall be deleted and replaced in its entirety so that the amended Section 2-4.5 shall read as follows:

2-4.5 Abusive Utilizers of Pharmacy Services

The CONTRACTOR shall have policies and procedures in place to identify, monitor and restrict, if necessary, utilization of services by individuals identified by TENNCARE or the CONTRACTOR as abusive utilizers of pharmacy services. The CONTRACTOR shall submit said policies and procedures for TENNCARE approval. TENNCARE shall respond to the CONTRACTOR's request for approval within thirty (30) days. Enrollees who disagree with such restrictions may appeal such restrictions pursuant to the medically necessary provisions of the TennCare hearing rules.

- 28. Section 2-4.7.6 shall be deleted in its entirety.
- 29. Section 2-4 shall be amended by adding a new Section 2-4.10, and renumbering the existing Section 2-4.10 as Section 2-4.11 so that the new Section 2-4.10 shall read as follows:

2-4.10 Compliance with Health Insurance Portability and Accountability Act (HIPAA) Requirements

2.4.10.1 In accordance with HIPAA regulations, the CONTRACTOR shall, at a minimum, comply with the following requirements:

- 2.4.10.1.1 As a party to this Agreement, the CONTRACTOR hereby acknowledges its designation as a covered entity under the HIPAA regulations;
- 2.4.10.1.2 The CONTRACTOR shall comply with the transactions and code set, privacy, and security regulations, once finalized, of the Health Insurance Portability and Accountability Act of 1996 by their designated compliance dates. Compliance includes meeting all required transaction formats and code sets with the specified data partner situations required under the regulations.
- 2.4.10.1.3 The CONTRACTOR shall transmit/receive from/to its provider, subcontractors, clearinghouses and TENNCARE all transactions and code sets required by the HIPAA regulations in the appropriate standard formats as specified under the law and as directed by TENNCARE so long as TENNCARE direction does not conflict with the law;
- 2.4.10.1.4 The CONTRACTOR shall agree that if it is not in compliance with all applicable standards defined within the transactions and code sets, privacy, security and all subsequent HIPAA standards, that it will be in breach of this Agreement and will then take all reasonable steps to cure the breach or end the violation as applicable. Since inability to meet the transactions and code sets requirements, as well as the privacy and security requirements can bring basic business practices between TENNCARE and the CONTRACTOR and between the CONTRACTOR and its providers and/or subcontractors to a halt, if for any reason the CONTRACTOR cannot meet the requirements of this Section, TENNCARE may terminate this Agreement in accordance with Section 6-2.2;
- 2.4.10.1.5 Protected Health Information (PHI) data exchanged between the CONTRACTOR and TENNCARE is intended to be used only for the

purposes of health care operations, payment and oversight and its related functions. All PHI data not transmitted for the purposes of health care operations and its related functions, or for purposes allowed under the federal HIPAA regulations will be de-identified to protect the individual enrollee's PHI under the privacy act;

- 2.4.10.1.6 Disclosures of Protected Health Information from the CONTRACTOR to TENNCARE shall be restricted as specified in the HIPAA regulations and will be permitted for the purposes of: health care operation, payment and oversight, obtaining premium bids for providing health coverage, modifying, amending or terminating the group health plan. Disclosures to TENNCARE from the CONTRACTOR shall be as permitted and/or required under the law;
- 2.4.10.1.7 The CONTRACTOR shall report to TENNCARE within five (5) days of becoming aware of any use or disclosure of Protected Health Information in violation of this Agreement by the CONTRACTOR, its officers, directors, employees, subcontractors or agents or by a third party to which the CONTRACTOR disclosed Protected Health Information;
- 2.4.10.1.8 The CONTRACTOR shall specify in its agreements with any agent or subcontractor of the CONTRACTOR that will have access to Protected Health Information that such agent or subcontractor agrees to be bound by the same restrictions, terms and conditions that apply to the CONTRACTOR pursuant to this Section;
- 2.4.10.1.9 The CONTRACTOR shall make available to TENNCARE enrollees the right to amend their Protected Health Information data in accordance with the federal HIPAA regulations. The CONTRACTOR shall also send information to enrollees educating them of their rights and necessary steps in this regard;
- 2.4.10.1.10 The CONTRACTOR shall make an enrollee's PHI data accessible to TENNCARE immediately upon request by TENNCARE;
- 2.4.10.1.11 The CONTRACTOR shall make available to TENNCARE within ten (10) days of notice by TENNCARE to the CONTRACTOR such information as in the CONTRACTOR'S possession and is required for TENNCARE to make the accounting of disclosures required by 45 CFR § 164.528. At a minimum, the CONTRACTOR shall provide TENNCARE with the following information:
 - 1. the date of disclosure
 - 2. the name of the entity or person who received the HIPAA protected information, and if known, the address of such entity or person
 - 3. a brief description of the Protected Health Information disclosed, and
 - 4. a brief statement of the purpose of such disclosure which includes an explanation of the basis for such disclosure.

In the event that the request for an accounting of disclosures is submitted directly to the CONTRACTOR, the CONTRACTOR shall within two (2) days forward such request to TENNCARE. It shall be TENNCARE'S responsibility to prepare and deliver any such accounting requested. Additionally, the CONTRACTOR shall institute an appropriate record keeping process and procedures and policies to enable the CONTRACTOR to comply with the requirements of this Section;

- 2.4.10.1.12 The CONTRACTOR shall make its internal policies and procedures, records and other documentation related to the use and disclosure of Protected Health Information available to the Secretary of Health and Human Services for the purposes of determining compliance with the HIPAA regulations upon request;
- 2.4.10.1.13 The CONTRACTOR shall create and adopt policies and procedures to periodically audit adherence to all HIPAA regulations;
- 2.4.10.1.14 The CONTRACTOR shall agree to the return or destruction of all Protected Health Information received from, created, or received by the CONTRACTOR;
- 2.4.10.1.15 The CONTRACTOR shall implement all appropriate administrative, technical and physical safeguards to prevent the use or disclosure of PHI other than pursuant to the terms and conditions of this Agreement;
- 2.4.10.1.16 The CONTRACTOR shall set up appropriate mechanisms to ensure minimum necessary access of their staff to Protected Health Information;
- 2.4.10.1.17 The CONTRACTOR shall create and implement policies and procedures to address present and future HIPAA regulation requirements as needed to include: use and disclosure of data; de-identification of data; minimum necessity access; accounting of disclosures; patients rights to amend, access, request restrictions, and right to file a complaint;
- 2.4.10.1.18 The CONTRACTOR shall provide an appropriate level of training to its staff and enrollees regarding HIPAA related policies, procedures, enrollee rights and penalties prior to the HIPAA implementation deadlines and at appropriate intervals thereafter;
- 2.4.10.1.19 The CONTRACTOR shall be allowed to use and receive information from TENNCARE where necessary for the management and administration of this Agreement and to carry out business operations;
- 2.4.10.1.20 The CONTRACTOR shall be permitted to use and disclose PHI for the CONTRACTOR'S own legal responsibilities;
- 2.4.10.1.21 The CONTRACTOR will adopt the appropriate procedures and access safeguards to restrict and regulate access to and use by CONTRACTOR employees and other persons performing work for said CONTRACTOR to have only minimum necessary access to personally identifiable data within their organization;

Amendment 1 (continued)

- 2.4.10.1.22 The CONTRACTOR will continue to protect personally identifiable information relating to individuals who are deceased;
 - 2.4.10.1.23 The CONTRACTOR will be responsible for informing its enrollee's of their privacy rights in the manner specified under the regulations;
 - 2.4.10.1.24 The CONTRACTOR must make available protected health information in accordance with 45 CFR § 164.524;
 - 2.4.10.1.25 The CONTRACTOR must make available protected health information for amendment and incorporate any amendments to protected health information in accordance with 45 CFR §164.526; and
 - 2.4.10.1.26 The CONTRACTOR shall obtain a third (3rd) party certification of their HIPAA transaction compliance before July 1, 2003.
- 2.4.10.2 In accordance with HIPAA regulations, TENNCARE shall, at a minimum, adhere to the following guidelines:
- 2.4.10.2.1 TENNCARE shall make its individually identifiable health information available to enrollees for amendment and access as specified and restricted under the federal HIPAA regulations.
 - 2.4.10.2.2 TENNCARE shall set up policies and procedures for minimum necessary access to individually identifiable health information with its staff regarding plan administration and oversight.
 - 2.4.10.2.3 TENNCARE shall adopt a mechanism for resolving any issues of non-compliance as required by law.
 - 2.4.10.2.4 TENNCARE shall establish similar HIPAA data partner agreements with its subcontractors and other business associates.
30. Section 2-6.2.c.1 shall be deleted in its entirety and the amended Section 2-6.2.c.1 shall read as follows:
1. Member Handbooks. Member handbooks must be approved by TennCare prior to distribution. Member handbooks must be distributed to enrollees within thirty (30) days of receipt of notice of enrollment in the CONTRACTOR's plan. In situations where there is more than one enrollee in a TennCare case, it shall be acceptable for the CONTRACTOR to mail one (1) member handbook to each address listed for the enrollee's TennCare case number when there is more than one (1) new enrollee assigned to the same case number at the time of enrollment and when subsequent updated member handbooks are mailed to enrollees. Should a single individual be enrolled and be added into an existing case, a member handbook must be mailed to that individual regardless of whether or not a member handbook has been previously mailed to enrollees in the existing case. However, the CONTRACTOR shall maintain and provide, as appropriate, two (2) separate versions of the CONTRACTOR's TennCare Member Handbook for the specific population being served for the purpose of describing Medicaid Benefits to the Medicaid population and Standard Benefits to the Standard population. Each member handbook shall, at a minimum, be in accordance with the following guidelines:
 - a. Must be in accordance with all applicable requirements as described in Section 2-6 of this Agreement;

Amendment 1 (continued)

- b. Shall include a table of contents;
- c. Shall include an explanation on how members will be notified of member specific information such as effective date of enrollment;
- d. Shall include a description of services provided including limitations, exclusions, and out-of-plan use;
- e. Shall include a description of cost share responsibilities for enrollees including an explanation that providers and/or the MCO may utilize whatever legal actions that are available to collect these amounts;
- f. Shall include information about preventive services for adults and children, including EPSDT for Medicaid eligibles to include a listing of preventive services and notice that preventive services are at no cost and without cost share responsibilities;
- g. Shall include procedures for obtaining required services, including procedures for obtaining referrals to specialists as well as procedures for obtaining referrals to providers outside of the plan. The handbook should advise members that if they need a service that is not available within the plan, they will be referred to a provider outside of the plan and any co-payment requirements would be the same as if this provider were in the plan;
- h. Shall include an explanation of emergency services and procedures on how to obtain emergency services both in and out of the CONTRACTOR's service area;
- i. Shall include information on how to access the primary care provider on a 24-hour basis. The handbook may encourage members to contact this 24-hour service when they have questions as to whether they should go to the emergency room;
- j. Shall include appeal procedures as described in Section 2-8 of this Agreement;
- k. Shall include notice to the enrollee that in addition to the enrollee's right to file an appeal for actions taken by the CONTRACTOR, the enrollee shall have the right to request reassessment of eligibility related decisions directly to TENNCARE;
- l. Shall include written policies on member rights and responsibilities, pursuant to Quality Standard X of Attachment II of this Agreement;
- m. Shall include written information concerning advance directives as described in the Code of Federal Regulations, 42 CFR 489 Subpart I and in accordance with 42 CFR 417.436.(d);
- n. Shall include notice to the enrollee that enrollment in the CONTRACTOR's plan invalidates any prior authorization for services granted by another plan but not utilized by the enrollee prior to the enrollee's enrollment into the CONTRACTOR's plan and notice of continuation of care when entering the CONTRACTOR's plan as described in Section 2-7.1;
- o. Shall include notice to the enrollee that it is the member's responsibility to notify the CONTRACTOR and the TENNCARE agency each and every time the member moves to a new address;

- p. Shall include notice to the enrollee that a new enrollee may request to change MCO plans at anytime during the forty-five (45) day period immediately following their initial enrollment in a MCO plan, subject to the capacity of the selected MCO to accept additional enrollees and any restrictions limiting enrollment levels established by TENNCARE. This process will require the enrollee to notify the State in a form that will be prescribed by the State;
- q. Shall include notice to the enrollee that the enrollee may change plans, unless otherwise specified by TennCare, during the next choice period as described in Section 4 of this Agreement and shall have a forty-five (45) day period immediately following the enrollment, as requested during said choice period, in a new plan to request to change plans, subject to the capacity of the selected MCO to accept additional enrollees and any restrictions limiting enrollment levels established by TENNCARE;
- r. Shall include notice to enrollee of their right to disenroll from the TennCare program at any time with instructions to contact TENNCARE for disenrollment forms and additional information on disenrollment;
- s. Shall include the toll free telephone number for TENNCARE with a statement that the enrollee may contact the plan or TENNCARE regarding questions about TennCare. The TennCare hotline number is 1-800-669-1851;
- t. Shall include information on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free; and
- u. The CONTRACTOR shall include information educating enrollees of their rights and necessary steps to amend their data in accordance with HIPAA regulations.

There are certain selected requirements of those described above which need to be provided uniformly in all handbooks so that members have, to include but not be limited to, a clear understanding of benefits covered, exclusions, cost sharing responsibilities, members responsibilities to respond to requests for information (re: address, employment, third party liability, etc.), emergency services, appeal processes, appeal rights, rights to change plans and to disenroll from TennCare, and acceptable reasons for disenrollment. The CONTRACTOR shall use specific language provided by TENNCARE to describe these requirements and other requirements as identified by TENNCARE.

At such time that TENNCARE provides the CONTRACTOR with a standardized format or standardized language for a member handbook, the CONTRACTOR shall agree to utilize the format and make appropriate additions and/or revisions as required by TENNCARE.

- 31. Section 2-6.2.c.2 shall be deleted in its entirety and replaced by a new Section 2-6.2.c.2 which shall read as follows:
 - 2. Quarterly Newsletter. The CONTRACTOR shall, at a minimum, distribute on a quarterly basis a newsletter to all enrollees which is intended to educate the enrollee to the managed care system, proper utilization of services, etc., and encourage utilization of preventive care services. The CONTRACTOR shall include the following information in each newsletter:
 - a. specific articles or other specific information as described when requested by TENNCARE. Such requests by TENNCARE shall be limited to two hundred (200)

words and shall be reasonable including sufficient notification of information to be included; and

- b. the procedure on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free; and
- c. For TennCare Medicaid enrollees, EPSDT information, including but not limited to, encouragement to obtain screenings and other preventive care services.

Not more than one hundred twenty (120) calendar days shall elapse between dissemination of this information. In order to satisfy the requirement to distribute the quarterly newsletter to all enrollees, it shall be acceptable to mail one (1) quarterly newsletter to each address associated with the enrollees TennCare case number. In addition to the prior authorization requirement regarding dissemination of materials to enrollees, the CONTRACTOR shall also submit to TENNCARE, ten (10) final copies of the newsletter and the date that the information was mailed to enrollees along with an invoice or other type of documentation to indicate the date and volume of the quarterly newsletter mailing.

32. Section 2-6.2.c shall be amended by adding a new Section 2-6.2.c.4 which shall read as follows:

- 4. The CONTRACTOR shall be responsible for distributing provider directories to new members within thirty (30) calendar days of receipt of notification of enrollment in the plan. The CONTRACTOR shall also be responsible for redistribution of updated provider information on a regular basis. Upon the CONTRACTOR's next printing, the provider directories shall include the following: names, locations, telephone numbers, office hours, non-English languages spoken by current network providers, and identification of providers accepting new patients. Enrollee provider directories, and any revisions thereto, shall be submitted to TENNCARE for approval prior to distribution to enrollees. Each submission shall include a paper and an electronic copy. The text of the directory shall be in Microsoft Word or Adobe (PDF) format. In addition, the provider information used to populate the enrollee provider directory shall be submitted as a TXT file or such format as otherwise approved by TENNCARE and be produced using the same extract process as the actual enrollee provider directory. In situations where there is more than one enrollee in a TennCare case, it shall be acceptable for the CONTRACTOR to mail one (1) provider directory to each address listed for the enrollee's TennCare case number when there is more than one (1) new enrollee assigned to the same case number at the time of enrollment and when subsequent updated provider directories are mailed to enrollees. Should a single individual be enrolled and be added into an existing case, a provider directory must be mailed to that individual regardless of whether or not a provider directory has been previously mailed to enrollees in the existing case. These updates shall be maintained in accordance with Section 2-1.o of this Agreement.

33. Section 2-6.5.a shall be deleted in its entirety and replaced by a new Section 2-6.5.a which shall read as follows:

- a. If the CONTRACTOR chooses to prepare a marketing plan, the CONTRACTOR shall submit a detailed description of its marketing plan for approval. Further, The CONTRACTOR shall submit any materials it intends to use and a description of any marketing activities to be held prior to implementation or use. This includes but is not limited to all policies and manuals, advertisement copy, brochures, posters, fact sheets, video tapes, story boards for the production of videos, audio tapes, newsletters, any and all other forms of advertising as well as any other forms of public contact such as participation in health fairs and/or telemarketing scripts.

34. Section 2-6.6.4.c shall be amended by deleting the second sentence so that the amended Section 2-6.6.4.c shall read as follows:

c. The word "free" can only be used if the service is no cost to all members. If members have cost share responsibilities, the service is not free. Any conditions of payments must be clearly and conspicuously disclosed in close proximity to the "free" good or service offer.

35. Section 2-6.6 shall be amended by adding a new Sub-Section 2-6.6.6 which shall read as follows:

6. The CONTRACTOR shall develop a written procedure for the provision of language interpretation and translation services for enrollees with Limited English Proficiency. The CONTRACTOR shall provide instruction for its staff and all direct service sub-contractors regarding the procedure.

36. Section 2-7 shall be amended by adding new text to the end of the existing paragraph so that the amended Section 2-7 shall read as follows:

2-7 Medical Management

The Contractor shall provide the State with two (2) written copies outlining its medical management procedures. Additionally, the Contractor shall obtain approval from the state, in writing, prior to implementing any changes, revisions, additions and/or deletions in these procedures unless otherwise directed or approved by TENNCARE or by an alternate procedure approved by TENNCARE.

37. The second paragraph of Section 2-8 shall be amended by adding new text in the existing fifth sentence and adding a new sentence to the end of the second paragraph so that the amended Section 2-8 shall read as follows:

2-8 Appeals

All enrollees shall be afforded the right to file a appeal. The CONTRACTOR shall refer all enrollees who are dissatisfied with the CONTRACTOR's initial response to the appeal coordinator for the appropriate action.

The enrollees shall have the right to file appeals regarding adverse actions taken by the CONTRACTOR. For purposes of this requirement, appeal shall mean an enrollee's right to contest verbally or in writing, any adverse action taken by the CONTRACTOR to deny, reduce, terminate, delay or suspend a covered service as well as any other acts or omissions of the CONTRACTOR which impair the quality, timeliness, or availability of such benefits. The CONTRACTOR shall provide readable materials reviewed and approved by TENNCARE, informing enrollees of their appeal rights. The CONTRACTOR has internal appeal procedures for both TennCare Medicaid enrollees as well as TennCare Standard enrollees in accordance with TennCare rule 1200-13-12-.11 or any applicable TennCare rules, subsequent amendments, TennCare Waiver or subsequent Court Orders governing the appeals process.

A portion of the regularly scheduled Quality Improvement meetings, as described in Section 2-9.6 shall be devoted to the review of enrollee appeals that have been received and resolved. The appeal procedures shall be governed by the following guidelines which are in accordance with TennCare policy as specified in TennCare rules and regulations and any and all Court Orders.

2-8.1 Appeals

The CONTRACTOR's appeal process shall be submitted for review and approval and shall include, at a minimum, the following:

1. The CONTRACTOR shall have a contact person appointed at each service site. Said person will be knowledgeable of appeal procedures and direct all appeals whether the appeal is verbal or the enrollee chooses to file in writing. Should an enrollee choose to appeal in writing, the enrollee will be instructed to file via mail to the designated P. O. Box for appeals related to the CONTRACTOR;
2. There shall be sufficient support staff (clerical and professional) available to process appeals in accordance with TennCare requirements related to the appeal of Adverse Actions Affecting a TennCare Program Enrollee. Staff shall be knowledgeable about applicable state and federal law and all court orders governing appeal procedures, as they become effective. This shall include, but not be limited to, appointed staff members and phone numbers identified to TENNCARE where appropriate staff may be reached;
3. Staff shall be educated concerning the importance of the procedure and the rights of the enrollee and the timeframes in which action must be taken by the CONTRACTOR regarding the handling and disposition of an appeal;
4. The appropriate individual or body within the plan having decision-making authority as part of the appeal procedure shall be identified;
5. The CONTRACTOR shall have the ability to take telephone appeals and accommodate persons with disabilities during the appeals process. Furthermore, appeal forms shall be available at each service site and by contacting the CONTRACTOR. However, enrollees shall not be required to use an appeal form in order to file an appeal;
6. Upon request, the enrollee shall be provided a TENNCARE approved appeal form(s);
7. All appellants shall have the right to reasonable assistance by the CONTRACTOR during the appeal process;
8. At any point in the appeal process, TENNCARE shall have the authority to remove an enrollee from the CONTRACTOR's plan when it is determined that such removal is in the best interest of the enrollee and TENNCARE;
9. The CONTRACTOR shall obtain a report from their pharmacy benefits manager (PBM) on a daily basis that identifies all physicians who have prescribed non-formulary prescription drugs. The CONTRACTOR shall use this report as a basis to contact, by telephone or fax, ninety-five percent (95%) of physicians (or a provider practicing with the prescribing physician) who wrote prescriptions, for more than a fourteen (14) calendar day supply, by the fifth (5th) calendar day from the date the prescription was filled, for the purpose of educating the physician about a prescription drug that is on the CONTRACTOR's formulary

that the physician may prescribe as an alternative and to encourage the physician to contact the pharmacy and change the prescription accordingly; any prescriber who cannot be identified through a unique DEA number shall be excluded from this requirement; and

10. TENNCARE may develop additional appeal process guidelines or rules, including requirements as to content and timing of notices to enrollees, which shall be followed by the CONTRACTOR, if TENNCARE determines that it is in the best interest of the TennCare Program or if necessary to comply with federal or judicial requirements. However, CONTRACTOR shall not be precluded from challenging any judicial requirements and to the extent judicial requirements that are the basis of such additional guidelines or rules are stayed, reversed or otherwise rendered inapplicable, CONTRACTOR shall not be required to comply with such guidelines or rules during any period of such inapplicability.
38. Section 2-9.1.b shall be deleted in its entirety and replaced by a new Section 2-9.1.b which shall read as follows:
- b. The CONTRACTOR shall meet with representatives of the State upon request to discuss any problems and/or progress on matters outlined by the State. The CONTRACTOR shall have in attendance its Program Director, and representatives from its organizational units required to respond to topics identified by the State or the CONTRACTOR. The CONTRACTOR may be asked to provide information concerning its efforts on network development, provider training, attempts to locate non-responsive TennCare eligibles and trends in costs and utilization.
39. Section 2-9.2.b shall be amended to add a new item 10, 11, and 12 and renumber the existing item 10 as item 13. The new item 10, 11 and 12 shall read as follows:
10. The CONTRACTOR shall appoint Care Coordinators and Claim Coordinators in order to coordinate and resolve issues related to MCO/DBM coordination issues as described in Section 2-3.4 of this Agreement. Further, the CONTRACTOR shall appoint a Care Coordination Committee and a Claims Coordination Committee made up of the Care/Claim Coordinators and other staff as appropriate. A list with the names and phone numbers of said representatives shall be provided by the MCO to the DBM and TENNCARE.
 11. The CONTRACTOR shall appoint Care Coordinators and Claim Coordinators in order to coordinate and resolve issues related to MCO/BHO coordination issues as described in Section 2-3.5 of this Agreement. Further, the CONTRACTOR shall appoint a Care Coordination Committee and a Claims Coordination Committee made up of the Care/Claim Coordinators and other staff as appropriate. A list with the names and phone numbers of said representatives shall be provided by the MCO to the BHO, TENNCARE and TDMHDD.
 12. The CONTRACTOR shall appoint and identify in writing to TENNCARE a responsible contact available after hours for the "on-call" TennCare Solutions staff to contact with service issues, including but not limited to, pharmacy issues.
40. Section 2-9.5 shall be amended by adding the phrase "as well as a Non-Responsive File via CD Rom which shall include additional data elements as described in this Section" at the end of the sixth and eleventh sentences so that the amended Section 2-9.5 shall read as follows:

2-9.5 Location of Non-responsive TennCare Eligibles

The CONTRACTOR agrees to attempt to locate "non-responsive TennCare eligibles" that have been enrolled in the CONTRACTOR's plan. Non-responsive TennCare eligibles are persons identified by TennCare who have not responded to re-verification attempts and who have not (and whose family members have not) accessed services during the period of review. Within 90 days of identification, the CONTRACTOR shall attempt to reach each non-responsive TennCare eligible identified by TennCare to the CONTRACTOR and assigned to TennCare Select effective July 1, 2001. The CONTRACTOR shall attempt to reach each non-responsive TennCare eligible telephonically using the phone number provided by TennCare. Upon placement of the call, if the CONTRACTOR receives a message that the phone number has been changed, the CONTRACTOR shall update the enrollee's phone number in its system and make at least three documented attempts to contact said enrollee at the new number to obtain the enrollee's new address. If successful, the CONTRACTOR will forward this information to TennCare via the Weekly Enrollee Information Report as well as a Non-Responsive File via CD Rom which shall include additional data elements as described in this Section. If TennCare does not provide a telephone number, the CONTRACTOR shall make and document at least one attempt to contact the non-responsive TennCare eligible through other publicly available information resources. In addition, the CONTRACTOR shall monitor claims activity for non-responsive TennCare eligibles. In the event the CONTRACTOR receives a claim for payment on behalf of a non-responsive TennCare eligible, the CONTRACTOR shall contact the provider and request the enrollee's phone number and address on file with the provider. The CONTRACTOR shall make at least three documented attempts to contact the enrollee at the location provided by the provider to confirm the enrollee's address. Once confirmed, the CONTRACTOR shall forward this information to TennCare via the Weekly Enrollee Information Report as well as a Non-Responsive File via CD Rom which shall include additional data elements as described in this Section. The CONTRACTOR shall complete this process within 45 days for other non-responsive TennCare eligible as they are identified by TennCare to the CONTRACTOR.

41. Section 2-9.6.2 shall be amended by deleting the second sentence so that the amended Section 2-9.6.2 shall read as follows:

2-9.6.2 Performance Indicators

The CONTRACTOR shall demonstrate meaningful improvement towards achieving the benchmark level of performance for each performance indicator specified in Attachment II, Quality of Care Monitors. To be considered meaningful, the CONTRACTOR must demonstrate a 10-percentage point improvement, unless otherwise specified by TENNCARE, over the baseline or satisfaction of the specified benchmark level of performance. For the period July 1, 2001 through December 31, 2001 the baseline is the average calendar year 2000 TennCare MCO performance level for the equivalent populations. For the period January 1, 2002 through December 31, 2002, the baseline will be defined as the higher of the Contractor's performance level for July 1, 2001 through December 31, 2001 or the average MCO performance level for calendar year 2000. For the period January 1, 2003 through December 31, 2003 the baseline will be defined as the Contractor's performance level for calendar year 2002.

Performance indicator results shall be reported to TennCare within 90 days of the end of the calendar year. The CONTRACTOR shall develop and analyze performance indicators independently for SSI children (Group 2), children in state custody and transitioning out of State Custody (Groups 1.A and 1.B) and enrollees of the back-up population (Group 6). TennCare agrees to assist with the identification of Group 6 enrollees. The CONTRACTOR shall not be

required to develop and analyze performance indicators for enrollees in Groups 3, 4, or 5 as defined in Section 4 of this Agreement.

The CONTRACTOR's failure to demonstrate meaningful improvement toward benchmark levels of performance shall result in the CONTRACTOR being required to implement a corrective action plan as described in Section 2-16.

42. Section 2-9.6.4 shall be amended by adding a new paragraph to the end of the existing text so that the amended Section 2-9.6.4 shall read as follows:

2-9.6.4 Credentialing Verification Organization

The CONTRACTOR agrees to contract with the Credentialing Verification Organization (CVO) contracted by the State to verify credentials of all primary care provider and all other physicians (including specialists) that the MCO does not either credential itself for a commercial line of business or delegate responsibility of credentialing to a large provider group. The exemption to the requirement to utilize the CVO to verify credentials of a provider in cases where the MCO has credentialed the provider for a commercial line of business, shall only apply if an MCO's, or an MCO's parent company's, commercial line of business accounts for at least fifty (50) percent of its total book of business. Also for the purpose of this requirement a "large" provider group is a provider group with at least 100 providers unless otherwise specified by TENNCARE. The State has negotiated a rate and established a standard set of activities in its contract with the CVO. The CONTRACTOR shall have the right to obtain additional services from the CVO, however, nothing in this agreement requires the CONTRACTOR to contract with the CVO for the purpose of verifying credentials of providers who are not primary care providers or other physicians.

The CONTRACTOR shall secure a subcontract agreement with the CVO that has been contracted by the State to be effective no later than July 1, 2002, or a later date as determined by TENNCARE. The subcontract must be submitted to TENNCARE for approval in accordance with Section 2-17 of this Agreement. The CONTRACTOR agrees to reimburse the CVO \$60.79 per transaction within thirty (30) calendar days of receipt of an invoice for verification of credentials of all primary care providers and all other physicians (including specialists) that the MCO does not either credential itself for a commercial line of business or delegate responsibility of credentialing to a large provider group during the initial three (3) year contract period that the CVO is contracted with the State. During the optional two (2) year renewal periods, the CONTRACTOR shall agree to reimburse the CVO \$64.44 per transaction to verify credentials of all primary care providers and all other physicians (including specialists).

An MCO that has provided the State notice to terminate the TennCare program shall not be required to utilize the CVO to verify credentials of providers who were previously credentialed in accordance with applicable TennCare credentialing standards and requirements. Re-credentialing shall not be required until the expiration of the three (3) year term required by the Quality of Care Monitors (Attachment II). Upon expiration of the three (3) year term, Contractors shall utilize the State-contracted CVO to verify credentials of all primary care providers and all other physicians.

The CONTRACTOR shall establish policies and procedures to ensure adequate due process for any provider where the CONTRACTOR fails to contract with the provider based on information obtained from the CVO as to provider's credentials.

Amendment 1 (continued)

43. The third sentence in Section 2-9.7 b shall be amended by deleting the word "line" and replacing it with the word "transaction" before the word "fee".
44. Section 2-9.7 shall be amended by adding a new item j and k and renumbering the existing Item j as Item l so that the new Section 2-9.7.j and k shall read as follows:
- j. The CONTRACTOR shall assure, whether directly or through a Pharmacy Benefit Manager (PBM) that all pharmacy claims processors must return an electronic message back to the dispensing pharmacist instructing him/her to bill the current PBM/claims processor in the event the pharmacist misdirected a behavioral health drug claim or was unaware of a patient's Medicare/Medicaid dual eligibility status.
 - k. EPSDT screenings. For provider agreements executed after October 1, 2002, the CONTRACTOR shall reimburse EPSDT services on a fee-for-service basis.
45. Section 2-10.1 shall be amended by deleting and replacing in its entirety the second paragraph so that the amended Section 2-10.1 shall read as follows:

2-10.1 General Requirements

The CONTRACTOR is responsible for complying with all the reporting requirements established by TENNCARE. TENNCARE shall provide the CONTRACTOR with the appropriate reporting formats, instructions, submission timetables, and technical assistance when required. TENNCARE may, at its discretion, require the CONTRACTOR to submit new reports, to recreate, reconstruct or re-sort reports using the same or different reporting formats, instructions and submission timetables as specified by TENNCARE. Requests to submit new reports, recreate, reconstruct or re-sort said reports may be considered Ad Hoc reports or continuous reports and shall be due in accordance with the provisions in Section 6.8.2.1 of this Agreement. The minimum data elements required for reporting are outlined in Attachment XII of this Agreement.

TENNCARE may require the CONTRACTOR to submit reports via e-mail in place of hard copy reports or a mutually agreed upon electronic process. The CONTRACTOR shall transmit/receive from/to TENNCARE all transactions and code sets required by the HIPAA regulations in the appropriate standard formats as specified under the law and as directed by TENNCARE so a long as TENNCARE direction does not conflict with the law.

Failure to report information, as specified by TENNCARE, shall result in the assessment of liquidated damages as described in Section 6.8.2 of this Agreement.

46. Section 2-10.2.3 shall be deleted in its entirety and replaced by a new Section 2-10.2.3 which shall read as follows:

2-10.2.3 Eligibility and Administrative Payment Reconciliation

The CONTRACTOR shall reconcile enrollee eligibility data and administrative fee payments and submit written verification that the Contractor has an enrollment record for all enrollees for whom the Contractor has received an administrative fee payment. The CONTRACTOR shall also notify TennCare in the event it has enrollees for whom an administrative payment has not been made or an incorrect payment has been made. This report shall be submitted as follows:

Amendment 1 (continued)

1. On a quarterly basis or as approved by TENNCARE, with a one-month lag time. The report is due to TENNCARE by the end of the second month following the reporting period. For example, for the quarter ending September 30th, the report is due by the end of November and should include all data received through the end of October.
2. Reports shall include un-reconciled items on all reports until such time that TENNCARE notifies the CONTRACTOR otherwise.
3. The CONTRACTOR shall report this information in the formats described in Attachment XII, Exhibit M.

47. Section 2-10.3.2 and 2-10.3.3 shall be deleted in their entirety and replaced by a new Section 2-10.3.2 and 2-10.3.3 which shall read as follows.

2-10.3.2 Essential Hospital Services Chart

In accordance with Section 2-4.1 the CONTRACTOR shall submit a listing of essential hospital providers that are included in the CONTRACTOR's provider network on the Essential Hospital Services Chart in Attachment XII, Exhibit D by September 1 of each year for each of the Grand Regions in which it operates.

2-10.3.3 Specialty Physician Services Chart

In accordance with Section 2-4.1 the CONTRACTOR may submit a listing of specialty physician arrangements that the CONTRACTOR has in place on the Specialty Physician Services Chart in Attachment XII, Exhibit E by September 1 of each year, for each of the community service areas in which it is authorized to serve.

48. Section 2-10.11 shall be deleted and replaced in their entirety so that the amended Section 2-10.11 shall read as follows:

2-10.11 Cost and Utilization Summaries

The CONTRACTOR shall provide the reports specified below separately for each of the following populations on a quarterly basis for services paid during the previous quarter:

- (1) Children in State custody and children who are transitioning out of state custody (Groups 1.A and 1.B);
- (2) Children who are SSI eligible (Group 2); and
- (3) All other enrollees.

2-10.11.1 Prescription Drug Summary

The CONTRACTOR shall provide a listing of the top 25 prescription drug therapeutic classes by amount paid on a quarterly basis. These reports shall include the following data elements (does not apply to dual eligibles):

1. Rank
2. Therapeutic Class Name
3. Quantity Dispensed (e.g., 1 tube, 100 pills, 1000 ml., etc.)
4. Number of Prescriptions Filled
5. Dispensing Fee

6. Ingredient Cost
7. Total Amount Paid for Each Therapeutic Class
8. Amount Paid as a Percentage of Total Drug Payments

2-10.11.2 Top 25 Providers by Amount Paid

The CONTRACTOR shall provide a summary listing of the top 25 providers by amount paid on a quarterly basis. These reports shall include the following data elements:

1. Rank
2. Provider type
3. Provider Name
4. Street Address (Physical Location)
5. City
6. State
7. Zip Code
8. Amount Paid to Each Provider
9. Amount Paid as a Percentage of Total Provider Payments

2-10.11.3 Top 25 Inpatient Diagnosis by Frequency and Amount Paid

The CONTRACTOR shall identify and report to TennCare the top 25 most frequent inpatient diagnosis based on: (1) number of admissions; and (2) amount paid, on a quarterly basis. These reports shall include the following data elements:

- a. By Number of Admissions -
 1. Rank
 2. DRG Code (Diagnosis Code)
 3. Description
 4. Amount Paid
 5. Admits
 6. Admits as a Percentage of Total Admits
- b. By Amount Paid -
 1. Rank
 2. DRG Code (Diagnosis Code)
 3. Description
 4. Admits
 5. Amount Paid
 6. Amount Paid as a Percentage of total Inpatient Dollars

2-10.11.4 Top 25 Outpatient Diagnosis by Frequency and Amount Paid

The CONTRACTOR shall identify and report to TennCare the top 25 most frequent outpatient diagnosis based on: (1) number of visits; and (2) amount paid, on a quarterly basis. These reports shall include the following data elements:

- a. By Number of Visits -
 1. Rank
 2. Diagnosis code
 3. Description
 4. Amount Paid

5. Visits
 6. Visits as a percentage of Total Outpatient Visits
- b. By Amount Paid -
1. Rank
 2. Diagnosis Code
 3. Description
 4. Visits
 5. Amount Paid
 6. Amount Paid as a Percentage of Total Outpatient Payments

2-10.11.5 Top 10 Inpatient Surgical / Maternity Admissions by Frequency and Amount Paid

The CONTRACTOR shall identify and report to TennCare the top 10 most frequent inpatient surgical/maternity DRGs based on: (1) number of admissions; and (2) amount paid, on a quarterly basis. These reports shall include the following data elements:

- a. By Number of Admissions -
1. Rank
 2. DRG Code
 3. Description
 4. Amount Paid
 5. Number of Admissions
 6. Admissions as a Percentage of Total Admissions
- b. By Amount Paid
1. Rank
 2. DRG Code
 3. Description
 4. Number of Admissions
 5. Amount Paid
 6. Amount Paid as a Percentage of Total Inpatient Surgical/Maternity Payments

2-10.11.6 Top 10 Outpatient Surgical /Maternity Procedures by Frequency and Amount Paid

The CONTRACTOR shall identify and report to TennCare the top 10 most frequent outpatient surgical/maternity procedures based on: (1) number of procedures; and (2) amount paid, on a quarterly basis. These reports shall include the following data elements:

- a. By Number of Procedures -
1. Rank
 2. Procedure Code
 3. Description
 4. Amount Paid
 5. Number of Procedures
 6. Procedures as a Percentage of Total Surgical/Maternity Procedures

- b. By Amount Paid -
 - 1. Rank
 - 2. Procedure Code
 - 3. Description
 - 4. Amount Paid
 - 5. Number of Procedures
 - 6. Amount Paid as a Percentage of Total Outpatient Surgical/Maternity Payments

2-10.11.7 High-Cost Claimants

The CONTRACTOR shall identify and report to TennCare the number of enrollees who incurred claims in excess of twenty-five thousand dollars (\$25,000) on a rolling quarterly basis. The CONTRACTOR shall report the enrollee's age, sex, primary diagnosis, and amount paid by claim type for each enrollee. The name of the member shall be blinded in order to maintain confidentiality.

2-10.11.8 Cost and Utilization Reports

- a. The CONTRACTOR shall report Cost and Utilization information for: Groups 1.A and 1.B; Group 2; and for all other Groups by TennCare enrollee eligibility category as described in Attachment XII, Exhibits L.1 through L.6. CONTRACTOR shall submit a written explanation for how service data will be mapped to the categories identified in said Exhibits within thirty (30) days of the execution date of this Amendment. These reports shall be sent to TENNCARE on a quarterly basis and shall be due to TENNCARE one-hundred five (105) calendar days following the quarter for which the CONTRACTOR is reporting.
- b. In order to support federal reporting requirements, the CONTRACTOR shall provide the Cost and Utilization information specified in Attachment XII, Exhibits L.1 through L.4 and L.6, separately for individuals who are dually eligible for Medicaid and Medicare in response to an adhoc request from TennCare in accordance with the timeframes specified in Section 6-8.

- 49. Section 2-10.13 shall be deleted and replaced in its entirety so that the new Section 2-10.13 shall read as follows.

2-10.13 Medical Fund Target Monitoring Report

For the purpose of monitoring actual medical expenses, TennCare shall establish a Medical Fund Target by eligibility grouping for TennCare Select. Medical Fund Target Monitoring Report shall be submitted monthly with cumulative year to date calculation using the forms in Attachment XII, Exhibit J. The CONTRACTOR shall report all medical expenses relative to the Medical Fund Target established by TENNCARE and complete the supporting claims lag tables. Monthly expenditures shall be reported on a rolling basis by provider groupings including but not limited to (i) direct payment to providers for covered medical services, (ii) capitated payments to providers and (iii) subcontractors for covered medical services. The CONTRACTOR will submit these reports monthly, due by the 21st of the following month. This report shall be accompanied by a letter from an actuary, who may be an employee of the CONTRACTOR, indicating that the reports, including the estimate for incurred but not reported expenses, have been reviewed for

accuracy. The CONTRACTOR will also file this report with its NAIC filings. The incurred but not reported amount submitted in the Medical Fund Target Monitoring Report accompanying the March NAIC filing shall be certified by an actuary.

50. Section 2-10 shall be amended by adding a new Section 2-10.16 which shall read as follows:

2-10.16 HIPAA Reporting

As described in Sections 2-4.10 and 2-10.1, the CONTRACTOR shall transmit/receive from/to TENNCARE all transactions and code sets required by the HIPAA regulations in the appropriate standard formats as specified under the law and as directed by TENNCARE so a long as TENNCARE direction does not conflict with the law.

Further, the CONTRACTOR shall report to TENNCARE any use or disclosure of information not provided for by this Agreement of which it becomes aware.

Failure to comply with HIPAA reporting requirements may result in the application of liquidated damages as described in Section 6-8 or termination of this Agreement as described in Sections 2-4.10 and 6-2 of this Agreement.

51. Section 2-17 shall be amended by adding a new Section 2-17.e and a new Section 2-17.h and renumbering the existing Sections 2-17.e through 2-17.h accordingly, including any and all reference thereto throughout the Agreement. The new Section 2-17.e and 2-17.h shall read as follows:

- e. LEP Provisions. The CONTRACTOR shall provide instruction for all direct service sub-contractors regarding the CONTRACTOR's written procedure for the provision of language interpretation and translation services for enrollees with Limited English Proficiency.
- h. HIPAA Requirements. The CONTRACTOR shall require that all its subcontractors adhere to the HIPAA regulation requirements.

52. Section 2-18.f shall be amended by adding a new sentence in between the two existing sentences so that the amended Section 2-18.f shall read as follows:

- f. Specify that the provider may not refuse to provide medically necessary or covered preventive services to a TennCare patient under this Agreement for non-medical reasons, including, but not limited to, failure to pay applicable cost sharing responsibilities. Upon next renewal of provider agreements, the CONTRACTOR shall specify that effective January 1, 2003, the CONTRACTOR may require that a TennCare Standard enrollee pay applicable TennCare cost share responsibilities prior to receiving non-emergency services. However, until such time that an amendment to the provider agreements are executed, the CONTRACTOR shall include said provisions in the providers administrative manual or other such communications. However, the provider shall not be required to accept or continue treatment of a patient with whom the provider feels he/she cannot establish and/or maintain a professional relationship;

53. The first sentence of Section 2-18.ee shall be deleted in its entirety so that the amended Section 2-18.ee shall read as follows:

- ee. Specify that the TennCare Provider Independent Review of Disputed Claims process shall be available to providers to resolve non-emergency claims denied in whole or in part by the MCO as provided at T.C.A. 56-32-226(b).

Amendment 1 (continued)

54. Section 2-18.jj shall be deleted and replaced in its entirety so that the amended Section 2-18.jj shall read as follows:

jj. Specify that a provider shall have at least one hundred and twenty (120) calendar days from the date of rendering a health care service to file a claim with the CONTRACTOR and no more than one hundred eighty (180) calendar days from the date of rendering a health care service to file an initial claim with the CONTRACTOR except in situations regarding coordination of benefits or subrogation in which case the provider is pursuing payment from a third party or if an enrollee is enrolled in the plan with a retroactive eligibility date. At the next renewal or amendment period of the provider agreement, the CONTRACTOR shall specify that a provider shall have at least, but no more than one hundred and twenty (120) calendar days from the date of rendering a health care service to file a claim with the CONTRACTOR except in situations regarding coordination of benefits or subrogation in which case the provider is pursuing payment from a third party or if an enrollee is enrolled in the plan with a retroactive eligibility date. In situations of enrollment in the plan with a retroactive eligibility date, the minimum and maximum time frames for filing a claim shall begin on the date that the CONTRACTOR receives notification from TENNCARE of the enrollee's eligibility;

55. Section 2-18.nn shall be amended by adding a new sentence to the end of the existing text which shall read as follows:

nn. All provider agreements must include language which informs providers of the package of benefits that EPSDT offers and which requires providers to make treatment decisions based upon children's individual medical and behavioral health needs. A listing of the EPSDT benefit package is contained in Attachment IX of this Agreement. All provider agreements must contain language that references the EPSDT benefit package found in Attachment IX and the agreement shall either physically incorporate Attachment IX or include language to require that the attachment be furnished to the provider upon request. At the next renewal or amendment of provider agreements, this Attachment IX shall be deleted and replaced by the new reference and items found in Section 2-3.16.8 of this Agreement;

56. Section 2-24 shall be amended by adding a new Section 2-24.b and renumbering the existing Sections 2-24.b. through 2-24.h accordingly, including any and all reference thereto throughout the Agreement. The new Section 2-24.b shall read as follows:

b. The CONTRACTOR shall develop a written procedure for the provision of language interpretation and translation services for enrollees with Limited English Proficiency. The CONTRACTOR shall provide instruction for its staff, including but not limited to, the designated staff person for Title VI, and all direct service sub-contractors regarding the procedure.

57. Section 3 shall be deleted and replaced in its entirety so that the amended Section 3 shall read as follows:

3 REQUIREMENTS FOR CHILDREN IN STATE CUSTODY

The CONTRACTOR agrees to be the designated MCO carve-out entity for the delivery of services to children in state custody. The CONTRACTOR further agrees that at such time that any plan for children in State custody is provided and/or approved by the court, the CONTRACTOR shall administer this Agreement in accordance with the requirements of the court order. In the event that TENNCARE makes a determination that the requirements of the court order differ materially from the requirements specified in this Agreement, TENNCARE and the CONTRACTOR agree to negotiate the required amendments to this Agreement for the purpose of incorporating the requirements of the court order. TENNCARE and the CONTRACTOR

recognize and agree that said amendment shall reflect mutually agreed upon additional costs to the CONTRACTOR, if any, related to the requirements of the court order, which must be documented by the CONTRACTOR and approved by TENNCARE, for which TENNCARE will compensate the CONTRACTOR. Children in state custody are eligible for the same TennCare covered services as other TennCare eligible children, in accordance with their TennCare eligibility status (TennCare Medicaid or TennCare Standard). However, due to the special needs of this population, this Section specifies special requirements for the delivery of TennCare covered services for children who are eligible for participation in the carve-out.

3-1 CONTRACTOR Responsibilities

Responsibilities for the administration and operation of the plan for the provision of services to children in State custody are assigned to several parties (e.g., the Steering Panel, the Implementation Team, the Department of Children's Services, the Behavioral Health Organization, Center's of Excellence for children in or at risk of state custody, Dental Benefits Manager, TennCare and delivery system providers). The CONTRACTOR agrees to arrange for services and administer the plan in collaboration with these other entities as described by TennCare. The CONTRACTOR agrees to:

- a. Comply with any plan for children in State custody which has been provided and/or approved by the court on a schedule determined to be reasonable and in accordance with the requirements of the court.
- b. Participate on the Children with Special Health Needs (CSHN) Steering Panel.
- c. Recruit and contract with an adequate number of providers for Best Practice Network (BPN) with expertise in children's health problems in accordance with TennCare standards and the criteria of the plan for children in state custody and any subsequent plan for Children in State custody which has been provided and/or approved by the court.
- d. Recruit for areas identified by the Implementation Team () as having an inadequate network; contract with qualified and willing providers identified by the Implementation Team for areas (geographical or specialty) where a shortage is identified..
- e. Develop procedures for assigning children in state custody to BPN providers; work with the Steering Panel to develop the best policy and mechanism for maintaining a long standing relationship between a child and a PCP, when family along with providers or the state feel that disruption of this relationship would be detrimental to the child. This is especially critical for children with severe physical or behavioral problems with a long-term relationship with the provider.
- f. The CONTRACTOR agrees to implement and monitor provider use of best practice guidelines which have been drafted by the Center(s) of Excellence for children in or at risk of state custody in collaboration with the committee appointed by the Steering Panel.
- g. Continue to manage and be responsible for all aspects of the TennCare program as specified in contracts with TennCare. Distribute Best Practice guidelines to Best Practice Network providers when approved by the Steering Panel.
- h. Work with state to develop those services determined to be necessary by CSHN Steering Panel.

Amendment 1 (continued)

- i. Provide BPN-PCPs with a listing of behavioral health providers obtained from the TennCare BHO(s). TennCare shall require the BHO(s) to provide said listing to the CONTRACTOR for this purpose.
- j. Educate BPN-PCPs on medical management policies and coordination of care requirements.
- k. Ensure submission of encounter data from Best Practice Network providers.

3-1.1 Administration and Management

- a. Staff Requirements. A specific Department of Children's Services (DCS) liaison person or persons shall be identified, in writing, to TENNCARE and the DCS. The DCS liaison person(s) will be responsible for assisting DCS to assure compliance with EPSDT requirements and the coordination of care for children in custody and at prolonged risk of custody and shall support Best Practice Network Primary Care Providers (BPN-PCPs) as requested. The names, titles, addresses and contact numbers (phone, fax, etc.) shall be provided for each of the liaison persons to TENNCARE, DCS and BPN-PCPs. The liaison person(s) shall be available to TENNCARE and/or the DCS case managers, BPN-PCPs, and foster families for assistance. The number of specific liaison persons identified shall be adequate at all times to cover the number of children in or at prolonged risk of State custody enrolled in TennCare Select. Any staff changes in the identified liaison person(s) shall be reported in writing to TENNCARE and DCS within ten (10) calendar days of the change. BPN-PCPs shall be notified of any staff changes at least quarterly.

TENNCARE will coordinate the responsibility for training the DCS liaison(s) on issues dealing with the provision of EPSDT services to children in or at prolonged risk of State custody. The liaisons will assist DCS with care coordination for these children and will have the responsibility of facilitating the timely delivery of EPSDT services covered by the MCO. Assistance with care coordination will include identifying providers, scheduling appointments, and coordinating transportation (if appropriate), when requested.

3-1.2 Provider Network

- a. Adequate Capacity. The CONTRACTOR must maintain a provider network with adequate capacity to deliver covered services that meet the special needs of children in state custody. Indicators of an adequate network include:
 - 1. The CONTRACTOR meets the guidelines established by its contract with TennCare for a provider network (as specified in Section 2 and Section 3);
 - 2. The CONTRACTOR has enough providers to consistently meet the time lines of this plan for EPSDT screenings;
 - 3. The CONTRACTOR has sufficient types and numbers of providers to be able to consistently deliver services in a timely manner when ordered for a child; and
 - 4. The CONTRACTOR has within its network specialized health providers with sufficient expertise to deliver the covered services specified in this Agreement

recognized in the Best Practice Guidelines as being proven effective and needed by children in State custody.

- b. Provider Network Composition. In addition to maintaining a provider network in accordance with Section 2 of this Agreement, the CONTRACTOR shall maintain under contract, a Best Practice Network of providers including primary care physicians, medical sub specialists, and centers of excellence specifically engaged to serve children in state custody as specified below.

The TennCare Dental Benefits Manager shall assume responsibility for the provision and payment of dental benefits for children in state custody. However, the CONTRACTOR shall agree to provide assistance with the coordination of dental services to children in State custody.

3-1.2.1 Best Practice Network Primary Care Providers

- a. The CONTRACTOR shall maintain a Best Practice Network of Primary Care Physicians (BPN-PCPs) who are community pediatricians and family practice physicians who agree to provide care timely and manage all health care including coordination of referrals for needed assessments or subspecialty care and serve as an advocate for children in custody to assure they get appropriate care. Specifically, BPN-PCPs must agree to:
 1. Provide EPSDT screenings timely;
 2. Provide not only basic health care services, but also care coordination of all the health care services of children in custody;
 3. Refer to physical health and behavioral health professionals in the Best Practice Network for specialty care; refer to the Center of Excellence for Children in, or at risk, of state custody, Community Mental Health Center when indicated; coordinate referrals when indicated with MCO/BHO;
 4. Request telephone consultations with the Center of Excellence when indicated;
 5. Communicate with caregivers on plan of care;
 6. Maintain all health information on children assigned to them, regardless of who provides the care (Center of Excellence for children in, or at risk of, state custody, local specialist, behavioral health provider, other health care providers);
 7. Report to DCS Health Unit any time health information on a child is not forwarded in a timely manner to allow for appropriate evaluation and care;
 8. Forward medical files to newly assigned PCP and provide an initial consult when child is being transferred to a new geographical area or new MCO;
 9. Share health information with DCS and foster parents within confidentiality guidelines;
 10. Forward pertinent information to providers seeing child on referral;
 11. Utilize (and document usage) of Best Practice Guidelines for care when developed and adopted by the Steering Panel. Document rationale for variation from Best Practice guidelines;
 12. Review information provided by state or MCO/BHO on caring for children in State custody;

13. Participate in the evaluation of system and outcomes through representation on the CSHN Steering Panel;
 14. Participate in the MCO/BHO selected for children in custody;
 15. Participate in training related to health problems of children in custody or Best Practice Guidelines; and
 16. Develop health treatment plans and incorporate all treatment needs of the children they see.
- b. The BPN-PCPs must also agree to perform the following case management functions:
1. Maintenance of all health information on children including behavioral health;
 2. Coordinate health services and request assistance from DCS case manager in following up and assuring plan of care is implemented;
 3. Consult with the Center of Excellence or other behavioral health providers when additional help is needed in managing a case; and
 4. Notify DCS when he/she feels more intense case management is needed by DCS.
- c. The CONTRACTOR must insure that each DCS custody child is assigned to a Best Practice Network Primary Care Provider within thirty days of enrollment. However, if a child has an established relationship with a provider who is not in the Best Practice Network, but is willing to continue care for this child and is qualified and competent to provide the care, the CONTRACTOR will allow the PCP to continue to provide care and reimburse the provider for care at the same rate as Best Practice Network Providers, if requested by DCS or the child's legal guardian.
- d. The CONTRACTOR may penalize BPN-PCPs who do not comply with the required responsibilities specified in paragraph 3.1.2.1.a above. Any penalty to be assessed must be described in writing in the BPN-PCP's provider agreement and must be approved by the State.
- e. When the State develops an internet based system for health providers to track medical information for children in state custody, the CONTRACTOR shall assist with provider education efforts on the system and amend its BPN-PCP Agreements to require BPN-PCPs to input required information into the system.

3-1.2.2 Dental Providers

- a. The CONTRACTOR shall agree to provide assistance with the coordination of dental services to children in State custody.

3-1.2.3 Centers of Excellence for Children in or at Risk of State Custody

The CONTRACTOR shall maintain contracts with all sites in the state recognized as Centers of Excellence for children in or at risk of state custody (which includes tertiary pediatric care): Johnson City, Knoxville, Chattanooga, Nashville and Memphis. It is the State's intent to recognize these centers via a contract that acknowledges the State's designation of each qualified facility as a Center of Excellence. The CONTRACTOR

shall maintain contracts with each of these centers specifically for the provision of services to children in or at risk of state custody specified in the contract between the State and the COE.

3-1.2.4 Pediatric Sub-Specialists

The CONTRACTOR shall establish and maintain a network of pediatric sub-specialists in each of the five catchment areas in the state (Johnson City, Knoxville, Chattanooga, Nashville and Memphis) that includes each type of pediatric sub-specialist with admitting privileges at the catchment area tertiary pediatric center.

3-1.3 Safety-Net

- a. EPSDT – Physical Health Screenings. The CONTRACTOR shall include Local Health Departments in their provider network to serve as safety net providers for the provision of EPSDT services..
- b. EPSDT – Dental Screenings. Local Health Departments, in which dental services are available, will provide safety net services. As specified in Section 5, an enhanced EPSDT dental screening rate will be paid to the local health departments as well as any Best Practice network dentists. Whenever the dental network is inadequate and dental care is urgent, the CONTRACTOR shall arrange for an out-of-network provider to provide the care.

Effective October 1, 2002, the TennCare Dental Benefits Manager shall assume responsibility for the provision and payment of dental benefits. However, CONTRACTOR shall agree to cooperate and participate with any subsequent plan for Children in State custody which has been provided and/or approved by the court.

3-1.4 Provider Agreement Language

The CONTRACTOR shall include in its subcontracts and agreements with providers a provision which states that subcontractors and providers are not permitted to encourage or suggest, in writing or verbally, that TennCare children be placed into state custody in order to receive medical or behavioral services covered by TennCare.

3-1.5 Network Management

- a. Provider Education. The CONTRACTOR shall train the Best Practice Network on the roles and responsibilities of Best Practice Network Providers, including the requirement to use Best Practice Guidelines and maintain complete medical records, in accordance with the requirements listed at 3-1.2.1.
- b. Monitoring. The CONTRACTOR shall conduct a medical chart review two times over the course of the original eighteen months of this Agreement and once in calendar year 2003 of a statistically valid sample of each BPN provider's medical charts to document Best Practice Network provider compliance with the requirements of the plan for children in state custody and any subsequent plan related to the provision of services to children in State custody of which the provider received advance notice, including the use of Best Practice Guidelines and completion of all seven required components of initial EPSDT exams (or documentation explaining any reasons for not adhering to the guidelines or

completing the seven components of the exam). The sampling methodology employed must be approved by TennCare prior to use.

- c. Provider Profiling. The CONTRACTOR shall profile BPN-PCPs. Provider profiling for the Best Practice Network shall include the activities specified at 2-9.4.

3-1.6 BPN Training

The CONTRACTOR shall require Best Practice Network provider participation in training sessions provided by the Center of Excellence and disseminate training materials to Best Practice Network providers as requested. Participation in training may be by teleconference, interactive Internet program, or in-person. The CONTRACTOR shall develop a survey to be administered after each training session designed to solicit feedback on barriers to attendance from non-participating providers. The CONTRACTOR shall provide an analysis of the findings and recommendations for increasing participation within ninety days of the training session.

3-1.7 Service Delivery Requirements

In addition to satisfying the requirements of Section 2 of this Agreement for the delivery of services, the CONTRACTOR shall meet the following requirements for the delivery of services to children in state custody:

- a. Access and Availability of Services. The CONTRACTOR shall maintain a network with a sufficient number of Best Practice Network PCPs to consistently meet the timeline of securing and/or offering an available appointment for EPSDT screenings within 21 days of request, but not to exceed thirty (30) days of placement in state custody.
- b. Failure to Maintain Adequate Capacity in Network and Recruitment of Best Practice Network Providers. The CONTRACTOR shall recruit Best Practice Network providers who have appropriate credentials, are willing to follow BPN guidelines and are willing to participate in its network. DCS will report any incidences where providers are not available to deliver services within the time frames specified for EPSDT screenings or within the time frames specified as needed by the Best Practice Network Provider or to the Implementation Team and TennCare. The IT will keep records and report to TENNCARE in what areas of the state an inadequate network exists. The CONTRACTOR will be notified when reports indicate a network deficiency and when recruitment of additional providers is necessary.
- c. Mental Health and Substance Abuse Services. In addition to the requirements specified in Section 2-3.5, the following requirements shall pertain the coordination of mental health and substance abuse services for children in state custody:
 - 1. The CONTRACTOR shall not limit the types or number of behavioral services that may be provided by a Best Practice Network Primary Care Provider.
 - 2. The CONTRACTOR will direct its Best Practice Network Primary Care Providers to submit all claims for services with a primary behavioral health diagnosis code (ICD-9-CM 290.xx – 319.xx) to the CONTRACTOR for payment.

Amendment 1 (continued)

3. Prior approval shall not be required by the CONTRACTOR or the BHO in order for a Best Practice Network Primary Care Provider to refer children in state custody to a BHO Provider.
 4. The CONTRACTOR shall provide a listing of credentialed BPN-PCPs to the BHO periodically to facilitate coordination of care.
- d. Service Authorization. At such time that a procedure is implemented and described by TENNCARE, the Implementation Team shall be contacted for disposition when a covered service has been requested by a health care provider for a child in or at risk of state custody, and the CONTRACTOR denies or otherwise fails timely to provide that service or approve a less intense service which the provider or DCS feels is inadequate. Effective upon receipt of any plan for children in State custody which has been provided and/or approved by the court, the role of the Implementation Team may be modified.
- e. Services While Transitioning Out of Custody. Children transitioning out of State custody, shall continue to have access to Best Practice Network providers for a minimum period of six months unless specified otherwise by TENNCARE. The child transitioning out of state custody will remain in the CONTRACTOR's plan and the CONTRACTOR will continue to provide services in accordance with this Agreement, or any plan for Children in State custody which has been provided and/or approved by the court, unless the child's legal guardian elects for the child to receive services outside of the Best Practice Network. All services for "children in state custody" in this Agreement are applicable to children transitioning out of state custody for the time period specified by TENNCARE, which shall be six months unless otherwise specified by TENNCARE.

When a child goes home for a 90-day trial but is still in State custody, this will count for the first three months of transition time. The above services can also be continued for an additional number of months to be specified by TENNCARE, which shall be six months unless otherwise specified by TENNCARE, on a case by case basis for a total of 365 days from the time of custody termination for those children whom DCS or the PCP and the Implementation Team deem it appropriate to prevent them from returning to state custody.

- f. Children at Prolonged Risk of State Custody. Children that are deemed to be at prolonged risk of custody (to be defined by the Steering Panel) and that are identified to the CONTRACTOR by the state may continue to receive services through the Best Practice Network indefinitely.

3-1.8 Reporting Requirements

- a. After the initial assignment of children in state custody to TennCare Select, the CONTRACTOR shall submit to the State a report that identifies the name of each DCS child enrolled in TennCare Select, the child's ID number, the date the child was placed in state custody, the date the CONTRACTOR received notice of enrollment, and the date of the child's initial EPSDT exam, updated on a monthly basis, excluding children in transition.
- b. For enrollees who have been assigned Immediate Eligibility, the Contractor shall, after twenty-five (25) calendar days of immediate eligibility coverage, identify children whose immediate eligibility will end in twenty (20) calendar days to the DCS Program Coordinator of Health Advocacy.

3-1.9 Performance Guarantees

The CONTRACTOR agrees to be bound by the performance guarantees identified below for the duration of this Agreement.

a. Timeliness of Care

1. Ninety percent (90%) of initial EPSDT exams completed within 30 calendar days of placement in custody.

Penalty for Non-compliance: \$1000 per occurrence.

Measurement: Monthly enrollment log (3-1.8.a) as verified through encounter data submissions for the following six (6) months

2. The CONTRACTOR shall maintain a network with a sufficient number of Best Practice Network PCPs to consistently meet the timeline of securing and/or offering an available appointment for EPSDT screenings within 21 days of request.

Penalty for Non-compliance: \$1000 per occurrence

Measurement: Mutually agreed upon survey instrument

b. EPSDT

Ninety-five percent (95%) EPSDT screening compliance rate including all seven components, unless reasons for missing components are appropriately documented.

Penalty for Non-compliance: \$5,000 for each full percentage point below 95%

Measurement: Medical record review

c. Provider Training Survey

BPN provider training participation at least once a year by teleconference, interactive internet program or in-person.

Penalty for Non-compliance: \$25,000 for failure to timely complete training survey as specified in Section 3-1.6

Measurement: Timely submission of survey findings

3-2 Department of Children's Services Responsibilities

The Department of Children's Services shall be responsible for the following requirements related to the responsibilities of the CONTRACTOR:

- a. Notify the CONTRACTOR when a child enters state custody so that Immediate Eligibility can be established.
- b. Maintain responsibility of seeing that children in custody receive appropriate health services, including arranging the appointments for screenings. Report on number of children receiving EPSDT screenings in timely fashion.
- c. Provide care coordination and case management consistent with the *John B* Consent Decree and Medicaid regulations.
- d. Provide a representative to the CSHN Steering Panel.
- e. Provide training to staff to carry out the components of this plan.

3-3 TennCare Bureau Responsibilities

The TennCare Bureau shall be responsible for the following:

- a. Contract with the carve-out MCO and TENNCARE BHO(s), each with a statewide network that has expertise for children's physical, developmental and behavioral problems to provide care management services to children in State custody and children at "prolonged risk" of State custody (to be defined by the Steering Panel) using fee for service structure and an arrangement which decreases the financial risk for the MCO and BHO.
- b. Contract with the COE for any services needed to implement this plan (for child psychiatrist, training, other functions as negotiated)
- c. Require MCO and BHO to provide adequate encounter and financial data to determine the provided services and the cost of those services for children in State custody.
- d. Provide resources for staffing the CSHN Steering Panel and Implementation Team.
- e. Participate on the CSHN Steering Panel.
- f. Require the MCO/BHO to include in its subcontracts with providers a provision which states that the subcontractors are forbidden from encouraging or suggesting, in writing or verbally, TennCare children be placed into state custody to receive medical or behavioral treatments. But instead, they are to let families know that there are other options and refer them to the Implementation Team when they are unable to get behavioral health services and are at risk of coming into custody.
- g. Develop a process whereby children who are already enrolled in TennCare but may not be assigned to the custodial MCO/BHO will be reassigned as soon as TennCare has been informed that the child is in state custody or is at risk of state custody and should be placed in the custodial MCO/BHO. TennCare shall comply with any subsequent plan for Children in State custody which has been provided and/or approved by the court.

3-4 Implementation Team

The Implementation Team shall:

- a. Review MCO denials or delays for services and issue letter of authorization for those services it determines to be appropriate under the circumstances at such time that policies and procedures are established by TENNCARE.
- b. The Implementation Team is expressly granted access to the medical records (physical and behavioral) of those children the Implementation Team is required to assist. All of the medical records obtained by the Implementation Team shall be held in the strictest confidence, and shall not be released to any individual unless the requesting individual is expressly granted such access by law, or unless the Implementation Team is ordered to release them by a court of competent jurisdiction.
- c. Determine when children referred to them are at imminent risk of custody and need additional services provided to this group to prevent custody. (DCS will still perform this service also.)
- d. Identify areas where provider networks are inadequate from the problems the team experiences in obtaining services for children at risk of custody as well as those in custody. Recommend to MCOs and BHOs (both for the custody children and the other children in TennCare) where networks are inadequate.

58. Section 4-1.1.a shall be deleted and replaced in its entirety so that the amended Section 4-1.1.a shall read as follows:

General Provisions

- a. The State shall select TennCare eligibles and any Medicaid eligible authorized to be enrolled in a managed care organization under the authority of a 1915(b) waiver to be enrolled in TennCare Select. TennCare eligibles shall not be enrolled in TennCare Select with an effective date prior to July 1, 2001. The following TennCare eligibles may be enrolled:

- Group 1.A:** Children who are in DCS custody;
- Group 1.B:** Children who are transitioning out of DCS custody;
- Group 2:** Children under 21 who are SSI eligible;
- Group 3:** Children receiving services in an institution or as part of the State's Home and Community Based Service waiver in order to avoid being institutionalized;
- Group 4:** Enrollees residing out-of-state;
- Group 5:** Enrollees that have not responded to TennCare's attempts to contact; and
- Group 6:** Enrollees residing in areas with insufficient capacity in other TennCare MCOs

59. Section 4.1.1.d, e, and f shall be deleted and replaced in their entirety so that the amended Sections 4-1.1.d, e and f shall read as follows:

- d. The CONTRACTOR agrees to accept TennCare eligibles and any Medicaid eligible authorized to be enrolled in a managed care organization under the authority of a 1915(b) waiver other than those identified above upon receipt of notification from TENNCARE. The CONTRACTOR agrees to accept an administrative fee of \$13.84 per member per month for the period July 1, 2001 through June 30, 2002 and \$14.39 per member per month for the period July 1, 2002 through December 31, 2002 for these enrollees. However, should the State elect to carve out a high-risk TennCare eligible group(s), the administrative fee(s) associated with the group(s) will

Amendment 1 (continued)

be mutually agreed upon between the CONTRACTOR and the State prior to enrollment of this population in the CONTRACTOR's plan. Effective January 1, 2003, the CONTRACTOR agrees to accept administrative fees as specified in Section 5.1 as payment for these enrollees.

- e. The CONTRACTOR shall accept daily eligibility data from the State as well as DCS for children in state custody who are to be given immediate eligibility for a forty-five (45) day period.
- f. The CONTRACTOR agrees to accept a reasonable number of enrollees who have been selected by the State for enrollment, from any failed health plan in the CONTRACTOR's service area as well as any plan which is terminated in whole or in part, may become insolvent or discontinues service, or who reside in an area in which there is insufficient capacity in risk MCOs to enroll the population.

To the extent possible and practical, TENNCARE shall provide advance notice to the CONTRACTOR of the impending failure of one of the plans serving the area; however, failure by TENNCARE to provide advance notice shall not limit in any manner the responsibility of the CONTRACTOR to accept enrollees from failed TennCare MCOs. In the event the number of re-assigned enrollees exceeds 100,000 and TENNCARE was unable to provide ninety (90) days advance notice to the CONTRACTOR, TENNCARE will afford the CONTRACTOR a 90-day period of time to adjust operational processes in order to meet the contractual performance requirements prior to assessing any penalties against the CONTRACTOR. TennCare and the Contractor recognize that large increases and decreases in enrollment may be required by program needs.

60. Section 4.1.1 shall be amended by deleting part k., and l. in their entirety and replacing them by new Sections 4.1.1.k., and 4.1.1.l. which shall read as follows:

- k. Enrollment shall begin at 12:01 a.m. on the effective date that the enrollee is enrolled in the CONTRACTOR's plan and shall end at 12:00 midnight on the date that the enrollee is disenrolled pursuant to the criteria in TennCare policy and/or TennCare rules and regulations. Children and Women who are determined presumptively and/or immediately eligible are given immediate TennCare eligibility and a temporary identification form to confirm eligibility pending the issuance of a regular identification card by their selected MCO. The purpose of this temporary identification/eligibility confirmation form is to enable the women to access prenatal care at the earliest possible time and to ensure all children in DCS custody are provided with medical services, including EPSDT screenings. The CONTRACTOR shall be responsible for arranging for the provision of services and payment of all covered services during the period of enrollment.
- l. Enrollees selected for enrollment in the CONTRACTOR's plan by the State in Groups 1, 2, 3, 5 and 6 shall have one (1) opportunity, anytime during the forty-five (45) day period immediately following enrollment, to request to change MCO plans. Enrollees in Group 6 shall only be able to request to change MCO plans during this period to the extent capacity is available in another MCO serving the region. Once the initial forty-five (45) day change period has expired, the enrollee shall remain a member of the CONTRACTOR's plan until the following change period, or until the enrollee loses eligibility for TennCare.

61. Section 4-1.2(b) shall be deleted in its entirety and replaced by a new Section 4-1.2(b) which shall read as follows:

- (b) Names, locations, telephone numbers, office hours, non-English languages spoken by current network providers (including primary care providers, specialists and hospitals), and identification of providers accepting new patients. In situations where there is more than one enrollee in a

Amendment 1 (continued)

TennCare case, it shall be acceptable for the CONTRACTOR to mail one (1) provider directory to each address listed in the enrollees TennCare case number when there is more than one (1) new enrollee in a case at the time of enrollment and when subsequent updated provider directories are mailed to enrollees. These updates shall be maintained in accordance with Section 2-1.0 of this Agreement;

62. Section 4-1.3 shall be deleted and replaced in its entirety so that the amended Section 4-1.3 shall read as follows:

Provisions for Children in State Custody

- a. To decrease the likelihood of recidivism, the enrollment period for children in Group 1.A who are transitioning out of state custody shall be extended by a period to be determined by TENNCARE. Children will be assigned to Group 1.B during this post-custody transition period and shall continue to receive services as specified in Section 3 including access to Best Practice Network providers, unless TENNCARE does not extend the enrollment period for children transitioning out of state custody. After the post-custody period of at least the period determined by TENNCARE, children assigned to Group 1.B shall be moved as appropriate, to Groups 2-6 and shall remain a member of the new group until the following change period, or until the child loses eligibility for TennCare. At the option of the State, children deemed to be at "prolonged" risk of state custody may remain in Group 1.B on an on-going basis.
- b. The CONTRACTOR agrees to accept daily eligibility updates in the form and format specified by TennCare for the purpose of identifying children in state custody and children transitioning out of state custody. Until such time as an indicator for children in state custody and children transitioning out of state custody can be added to the daily eligibility updates received from TennCare, the CONTRACTOR agrees to accept and process any adhoc report mutually agreed upon by the CONTRACTOR and TennCare to facilitate timely identification of children in state custody or children transitioning out of state custody.

63. Section 4-2.1.b shall be deleted and replaced by a new Section 4-2.1.b which shall read as follows:

- b. TENNCARE may disenroll enrollees that were originally enrolled due to insufficient capacity in other TENNCARE MCOs (Group 6) at any time. However, TENNCARE shall provide sixty (60) days advance written notice prior to any block transfer of enrollees from the CONTRACTOR's plan and re-enrollment into another TennCare MCO. TENNCARE shall provide ninety (90) days advance notice of any planned transfer of enrollees out of the Contractor's plan that would result in a decrease of 100,000 members or more. The preceding statement is not intended to provide advance notice of changes that occur during the course of an open enrollment period or that are due to an enrollee's choice.

64. Section 5-1 shall be deleted and replaced in its entirety so that the amended Section 5-1 shall read as follows:

a. The administrative fee paid shall be:

Enrollee Category ²	Effective July 1, 2001 – June 30, 2002	Effective July 1, 2002 – December 31, 2002
Group 1.A	\$21.84 PMPM	\$22.71 PMPM
Group 1.B	\$21.84 PMPM	\$22.71 PMPM
Group 2	\$21.84 PMPM	\$22.71 PMPM
Group 3	\$13.84 PMPM	\$14.39 PMPM
Group 4	\$13.84 PMPM	\$14.39 PMPM
Group 5	\$13.84 PMPM	\$14.39 PMPM
Group 6	\$13.84 PMPM	\$14.39 PMPM

b. Effective January 1, 2003, the administrative fee paid for enrollees in Group 1.A, Group 1.B and Group 2 shall be \$25.00 per member per month.

c. Effective January 1, 2003, the administrative fee paid for enrollees in Group 3, Group 4, Group 5 and Group 6 shall vary based on the total number of enrollees in these groups as follows:

Enrollment Level	Administrative Fee
0 to 99,999 enrollees	\$11.37
100,000 to 199,999 enrollees	\$11.25
200,000 to 299,999 enrollees	\$11.12
300,000 to 399,999 enrollees	\$11.00
400,000 to 499,999 enrollees	\$10.89
500,000 to 599,999 enrollees	\$10.68
600,000 to 699,999 enrollees	\$10.53
700,000 to 799,999 enrollees	\$10.38
800,000 to 899,999 enrollees	\$10.23
900,000 to 999,999 enrollees	\$10.08
1,000,000 or more enrollees	\$9.93

i. The applicable administrative fee shall be determined based upon the total number of enrollees in the month preceding the month in which payment is made to the Contractor as determined by TENNCARE. The administrative fee specified shall be applicable to all enrollees in Group 3, Group 4, Group 5 and Group 6 upon attainment of an enrollment level. For example, if enrollment for the month of February is 250,000 enrollees, the administrative fee payment for the month of March shall be \$11.12 per member per month for each Group 3, Group 4, Group 5 and Group 6 enrollee assigned to the CONTRACTOR during the month of March, adjusted as set forth in subparagraphs 5-1.d through 5-1.f, if applicable.

d. TennCare or its appointed agent shall make payment by the fifth working day of each month to the CONTRACTOR for the CONTRACTOR's satisfactory performance of its duties and responsibilities as set forth in this Agreement. Each month payment to the CONTRACTOR shall be equal to the number of enrollees certified by TENNCARE multiplied by the administrative fee for the appropriate enrollee category. The actual amount owed the CONTRACTOR for each

² As defined at 5.1.1.a.

enrollee shall be determined by dividing the appropriate monthly administrative fee by the number of days in the month and then multiplying the quotient of this transaction by the actual number of days the enrollee was enrolled in the plan.

- e. Payment for enrollees shall start the effective date of the enrollee's enrollment in the plan.
 - f. The CONTRACTOR agrees the State may retroactively recoup Administrative Fee payments for deceased enrollees. Retroactive recoupment will be deducted from the monthly payment for the following month. Payments may be recouped back to the date of death. This is the only provision whereby the State may retroactively recoup administrative fee payments from the CONTRACTOR for enrollees retroactively terminated from TennCare Select.
 - g. Effective January 1, 2002, administrative fee payments made in accordance with Section 5-1.b will not include payment for children in state custody for whom Immediate Eligibility was established in accordance with Section 2-3.17 and who were not subsequently found to be TennCare eligible. TennCare shall make a separate payment for said children upon receipt of an invoice from the CONTRACTOR. The invoice shall be submitted to TENNCARE in the form and format specified in Attachment XII, Exhibit N on a monthly basis. The administrative fee due shall be equal to the number of enrollees for whom Immediate Eligibility was established multiplied by a flat rate for the full 45 day eligibility period of \$25.00 per member.
65. Section 5-2.1.a shall be amended by deleting and replacing item number 3 so that it includes the information that was previously in Attachment 5.1, adding a new item 5 and renumbering the existing item 5 as 6. The amended Section 5-2.1 shall read as follows:

5-2.1 General Requirements

- a. Maximum Allowable Rates. Providers shall be paid according to BlueCare policies and procedures and reimbursement rates in effect as of March 1, 2001, unless otherwise directed by TennCare with the following exceptions:
 - 1. The payment rate for an initial EPSDT screening conducted by a Best Practice Network Primary Care Provider for a child in state custody shall be at the rate specified in Section 5.2.2.a.
 - 2. The payment rate for preventive dental services provided by a Best Practice Network Dental Provider on a child in state custody shall be at the rate specified in Section 5.2.2.b, unless otherwise specified by TENNCARE and until such services are carved out.
 - 3. The payment rate for all other preventive health services specified below for children (under age 21) may be increased up to 85% of the 2001 Medicare fee-schedule, unless otherwise specified by TENNCARE.

The CONTRACTOR shall make an enhanced payment, defined as eighty-five percent (85%) of the 2001 Medicare fee-schedule or the BlueCare reimbursement rates in effect as of March 1, 2001, whichever is greater, to Primary Care Providers for the provision of the following preventive medical services identified by the CPT procedure codes listed below, when billed for children less than 21 years of age. Payment rates for services reimbursed as a percentage of average wholesale price shall be adjusted in accordance with Section 5.2.1.a.4. of this Agreement.

Office Visits

NEW PATIENT	ESTABLISHED PATIENT
99431 – History and Evaluation of Normal newborn	99391 – Periodic reevaluation
99432 – Normal Newborn care other than a hospital or birthing setting	99392 – age 1 through 4 years
99381 – Initial evaluation	99393 – age 5 through 11 years
99382 – age 1 through 4 years	99394 – age 12 through 17 years
99383 – age 5 through 11 years	99395 – age 18 through 39 years
99384 – age 12 through 17 years	
99385 – age 18 through 39 years	

Counseling and Risk Factor Reduction Intervention

INDIVIDUAL	GROUP
99401 – approximately 15 minutes	99411 – approximately 30 minutes
99402 – approximately 30 minutes	99412 – approximately 60 minutes
99403 – approximately 45 minutes	
99404 – approximately 60 minutes	

Other Preventive Services

99420	Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal)
90700 – 90744	Immunizations
92551	Screening test, pure tone, air only (Audiologic function)
92552	Pure tone audiometry (threshold); air only

4. The payment rate for all services that are reimbursed as a percentage of average wholesale prices shall be adjusted with fluctuations in the average wholesale price. However, the “percentage” applied to determine the payment amount shall be equivalent to the percentage applied for BlueCare as of March 1, 2001.
 5. The initial utilization management and referral processes and requirements impacting provider reimbursement shall be those in effect for BlueCare and TennCare Select as of July 1, 2001 as specified in Attachment II. However, the State reserves the right to require the CONTRACTOR to modify these processes and requirements. The CONTRACTOR shall have sixty (60) days from the date of request to implement requested modifications.
 6. If there is a network deficiency that necessitates additional funding to remedy, the CONTRACTOR shall attempt to negotiate a reasonable rate on behalf of the State prior to recommending an increase in reimbursement rates. Once the negotiations are concluded, the CONTRACTOR shall submit a recommendation to the State in writing with supporting documentation justifying an increase in reimbursement rates. The CONTRACTOR may not implement a recommended change until receipt of written approval from TennCare.
- b. Annual Review. The maximum allowable reimbursement rates shall be reviewed on an annual basis.

66. Section 5-2.2 shall be deleted and replaced in its entirety so that the amended section 5-2.2 shall read as follows:

5-2.2 Best Practice Network Requirements

a. Enhanced Initial EPSDT Screening Rate. The CONTRACTOR shall make an enhanced payment to Best Practice Network Primary Care Providers for the initial EPSDT examination for children in state custody, when all seven (7) components of the exam have been completed. The seven components shall include: (1) A comprehensive health and development history to include both physical and mental health; (2) Comprehensive unclothed physical exam; (3) Appropriate vision and hearing assessment; (4) Laboratory testes appropriate for age and risk; (5) Dental screening and referral beginning at age 3; (6) Immunizations; (7) Health education (anticipatory guidance).

1. The procedure codes to be utilized when billing for the initial EPSDT exam are specified below. This language does not preclude the BPN-PCP from billing for other services separately, consistent with the CONTRACTOR's procedures for claims processing (e.g., lab). It is the responsibility of the CONTRACTOR to include in its Best Practice Network provider agreements a requirement that all seven components of the EPSDT exam are completed when an enhanced payment is made through a medical chart review. The CONTRACTOR should educate providers to document any barriers to completing all seven components (e.g. past history not available). The enhanced payment rate for the initial EPSDT screening exam shall be ninety-five percent (95%) of the 2001 Medicare fee-schedule. Effective December 1, 2001, the enhanced fee schedule shall be 100% of the 2001 Medicare fee schedule unless otherwise specified by TENNCARE.

NEW PATIENT	ESTABLISHED PATIENT
99431 – History and Examination of Normal Newborn	99391 – Periodic reevaluation
99432 – Normal Newborn care other than a hospital or birthing setting	99392 – age 1 through 4 years
99381 – Initial evaluation	99393 – age 5 through 11 years
99382 – age 1 through 4 years	99394 – age 12 through 17 years
99383 – age 5 through 11 years	99395 – age 18 through 39 years
99384 – age 12 through 17 years	
99385 – age 18 through 39 years	

If the BPN-PCP submits a claim with a procedure code for an established patient, the CONTRACTOR may only reimburse the provider at the enhanced payment rate if the claim is for the initial EPSDT exam upon placement in state custody. If the CONTRACTOR directs BPN-PCPs to only bill the initial EPSDT exam with the New Patient procedure code series identified above, the CONTRACTOR must notify and provide appropriate training to the provider and provider's billing staff to implement this billing procedure.

2. The CONTRACTOR shall conduct a medical chart review three times over the course of this Agreement of a statistically valid sample of each BPN-PCPs medical charts to ensure completion of all seven components of the initial EPSDT exam. The sampling methodology employed must be approved by TennCare prior to use. The CONTRACTOR shall recoup an amount equivalent

to the difference between the enhanced EPSDT screening payment rate for BPN-PCPs as described in Section 5-2.2.a and the standard EPSDT screening payment rate as described in Section 5-2.1.a, if it is determined upon medical chart review that the provider to whom payment was made failed to complete all seven components of the exam.

- b. Enhanced Dental Fee-Schedule. Until such time that Dental Services are carved out of this Agreement, the CONTRACTOR shall make an enhanced payment to Best Practice Network Dental Providers for children in state custody for preventive dental services, as specified below. Effective October 1, 2002, the CONTRACTOR shall not authorize payment for the following covered dental services:

D0120 -- Periodic Oral Evaluation	\$17.85
D0150 -- Comprehensive Oral Evaluation	\$17.85
D1110 -- Prophylaxis, children greater than 12 and less than 21 years of age	\$33.15
D1120 -- Prophylaxis, Child	\$23.80
D1351 -- Sealant, Per Tooth	\$19.55
D1203 -- Fluoride, Child	\$17.85
D1204 -- Fluoride, Adult -- when billed for children between ages 13 and 20	\$17.85

Effective December 1, 2001, the TennCare Select Dental Fee schedule shall be 75% of the Doral Fee Schedule as it existed as of December 1, 2001.

- c. Case Management. In exchange for performing additional care coordination and case management functions as specified in Section 3 of this Agreement, the CONTRACTOR shall pay Best Practice Network Primary Care Providers a case management fee of \$10 per member per month.

67. Section 5-3 shall be amended by inserting a new Section 5-1.g which shall read as follows:

- g. Immediate Eligibility. Medical service payments made in accordance with Section 5-3.a shall include payments to providers for services provided during a period of Immediate Eligibility. However, in order to facilitate the invoicing of DCS for services provided to children in state custody who are not TennCare eligible, the CONTRACTOR shall submit to TENNCARE an itemized listing of claims paid on behalf children in state custody for whom Immediate Eligibility was established in accordance with Section 2-3.17 and who were not subsequently found to be TennCare eligible, on a monthly basis in the form and format specified in Attachment XII, Exhibit N.

68. Attachment 5.1 shall be deleted and amended text from Attachment 5.1 shall be incorporated into Section 5-2.1a.3 of this Amendment.

69. Section 6-1 shall be amended by adding a new part q and r which shall read as follows:

- q. 42 USC Section 1396 et seq. (with the exception of those parts waived under the TennCare Section 1115(a) waiver).
- r. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended, Section 1171(5)(E) of the Social Security Act as enacted by HIPAA.

Amendment I (continued)

70. Section 6-26 shall be amended by deleting "2002" in the third sentence and replacing it with "2003", and inserting a new fourth sentence that shall read "At the mutual agreement of TennCare and the CONTRACTOR, this CONTRACT shall automatically renew for one additional twelve month period." so that the amended Section 6-26 shall read as follows:

6-26 Contract Term of this Agreement

This Agreement and its incorporated attachments, if any, as well as all Amendments to this Agreement, contain all of the terms and conditions agreed upon by the parties, and when executed by all parties, supersedes any prior agreements. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall be in effect from July 1, 2001, subject to approval by the U.S. Department of Health and Human Services, Health Care Financing Administration. The term of this Agreement shall expire on December 31, 2003.. At the mutual agreement of TennCare and the CONTRACTOR, this CONTRACT shall be renewable for an additional twelve month period.

Notwithstanding any provision herein to the contrary, the State may terminate this Agreement if the waiver governing TennCare is terminated. The documents referenced in the Agreement are on file with the CONTRACTOR and with TENNCARE and the CONTRACTOR is aware of their content. No other agreement, oral or otherwise regarding the subject matter of this Agreement, shall be deemed to exist or to bind any of the parties hereto.

70. Section 6-27 shall be deleted and replaced in its entirety so that the amended Section 6-27 shall read as follows:

Effective November 1, 2002, the CONTRACTOR agrees TENNCARE may assess penalties for failure to meet the Performance Guarantees specified below in addition to the intermediate sanctions and liquidated damages specified in Section 6-8. Penalties for failure to meet a performance guarantee shall not be passed on to a provider and/or subcontractor unless the penalty was caused due to an action or inaction of the provider and/or subcontractor. TENNCARE shall not apply penalties for failure to meet Specialist Provider Network Guarantee C.1 and C.2 and Network Adequacy Guarantee D.1, specified in the table below, if the CONTRACTOR is able to demonstrate that the failure to satisfy the guarantee occurred after a change in provider agreement terms directed to be made by TENNCARE, and that the failure is related to the required change in provider agreement terms. All penalties shall be considered an administrative cost to the CONTRACTOR.

Amendment 1 (continued)

Performance Area	Data Source	Definition	Guarantee	Penalty
A. Claims Payment Accuracy	Self-reported based on internal audit conducted on statistically valid random sample on a quarterly basis. Audit procedures and sample methodology to be submitted to TDCI for review and approval with first quarter's report.	Number of claims processed for payment and paid accurately upon initial submission divided by the total number of claims	97% of claims are paid accurately upon initial submission	\$5,000 for each full percentage point accuracy is below 97% for each quarter
B. Abandonment rate for Member Services line and Provider Services line	Weekly Activity Report	Percent of calls not answered; callers hang up while in queue	Less than 5% of calls not answered	\$25,000 for each full percentage point above 5% on a quarterly basis
C. Specialist Provider Network	Monthly Provider listing	Executed contract is a signed agreement with a provider to participate in the Contractor's network	1. Physician Specialists: Executed specialty physician contracts in all areas required by this Agreement for the following nine specialists: cardiology; gastroenterology; neurology; neurosurgery; otolaryngology; ophthalmology; orthopedics; oncology/hematology; and urology 2. Essential Hospital Services: Executed contract with at least one (1) Tertiary Care Center for each essential hospital service and at least one (1) Center of Excellence for People with AIDs	\$25,000 if ANY of the listed standards are not met, either individually or in combination on a monthly basis The penalty may be waived for Physician Specialists if the CONTRACTOR provides sufficient documentation to demonstrate that the deficiency is attributable to a lack of physician supply in the area. The penalty may be lowered to \$5,000 in the event the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE

Amendment 1 (continued)

Performance Area	Data Sources	Definition	Criteria	Penalty
F. EPSDT Screening and Medical Record Documentation	MCO Encounter Data and Medical Chart Audit	The EPSDT screening ratio, calculated in accordance with specifications for the HCFA-416 report, multiplied by the percentage of the required seven (7) screening components that are completed as determined through a statistically valid sample of medical records of the MCO's enrollees	Demonstrated active pursuit and completion of activities designed to increase the CONTRACTOR's EPSDT screening ratio and the percentage of screens that are completed and include all seven (7) required screening components	Development and implementation of a Corrective Action Plan pursuant to Section 2-16

71. Section 7-14 shall be deleted and replaced in its entirety so that the amended Section 7-14 shall read as follows:

7-14 Exigency Extension

At the option of the State, the CONTRACTOR agrees to continue services under this CONTRACT when TENNCARE determines that there is a public exigency that requires the contracted services to continue. Continuation of services pursuant to this Section shall be in three (3) month increments and the total of all public exigency extensions shall not exceed twelve (12) months. Thirty days notice shall be given by TENNCARE before this option is exercised. TENNCARE shall reimburse the CONTRACTOR during exigency at the established administrative fee in effect during the last six (6) months of this Agreement.

72. Parts I and II of Attachment I shall be deleted in their entirety and replaced with the following:

I. Items requiring prior approval by TENNCARE

- A. Fraud and Abuse Compliance Plan TENNCARE has thirty (30) calendar days to respond
- B. Provider Network TENNCARE has thirty (30) calendar days to respond
- C. Marketing/Enrollee Materials and/or Plans TENNCARE has fifteen (15) calendar days to respond
- D. EPSDT Policies and Procedures, including but not limited to: TENNCARE has thirty (30) calendar days to respond
 - Provider referral procedures for enrollees requiring further care
 - Appropriate record keeping
 - Follow-up process for enrollees who do not receive timely screenings

Amendment 1 (continued)

- | | | |
|------|---|---|
| E. | Drug Formulary (if closed) | TENNCARE has thirty (30) calendar days to respond |
| F. | Subcontracts | TENNCARE has thirty (30) calendar days to respond |
| G. | Indemnity language in provider agreements if different than standard indemnity language | TENNCARE has fifteen (15) calendar days to respond |
| H. | Quality Monitoring/Quality Improvement Process | TENNCARE has thirty (30) calendar days to respond |
| I. | Insurance and Bonding Plans | TENNCARE has fifteen (15) calendar days to respond |
| J. | Method of pharmacy restriction procedures for Pharmacy Abusers | TENNCARE has thirty (30) calendar days to respond |
| K. | MCO/BHO Coordination Agreement | TENNCARE has thirty (30) calendar days to respond |
| L. | Medical Management Policies and Procedures | TENNCARE has thirty (30) calendar days to respond |
| M. | Termination Plan | TENNCARE has thirty (30) calendar days to respond |
|
 | | |
| II. | <u>Deliverables which are the responsibility of the CONTRACTOR</u> | |
|
 | | |
| A. | Listing of referral providers in accordance with Section 2-4.4 | Due to providers within thirty (30) calendar days following the execution of this Agreement and quarterly thereafter on a calendar year schedule. Proof of compliance shall be sent to the Office of Contract Development and Compliance by the 30 th of the month following each quarter. |
| B. | FQHC Reporting in accordance with 2-4.9.1 and 2-10.12 | Due January 1 of each year to Office of Fiscal Services and Provider Networks |
| C. | Complete Drug Formulary; if CONTRACTOR utilizes a closed drug formulary, and a complete description of prior authorization criteria for each drug requiring prior authorization via electronic file in accordance with Section 3-13 | Due January 1 of each year to TENNCARE Pharmacy Director |
| D. | Quarterly Newsletter in accordance with Section 2-6.2 | Due quarterly, within one hundred twenty (120) calendar days of the prior quarters' newsletter to enrollees and to the Office of Contract Development and Compliance (10 copies) |

Amendment 1 (continued)

- | | | |
|----|--|---|
| E. | Identify key staff contacts in accordance with Section 2-10.10.2 and 2-9.2 | Due within thirty (30) calendar days of Agreement execution and within ten (10) business days of any changes to the Office of Contract Development and Compliance |
| F. | Performance Indicator Reporting in accordance with Section 2-9.6.2 and 2-10.14.4 | Annually, within ninety (90) calendar days of the end of the calendar year to the Office of the TennCare Medical Director |
| G. | Weekly Claims Activity Reporting in accordance with Section 2-10.6 | Weekly, by Wednesday of the following week to the Department of Commerce and Insurance, TennCare Division and the Office of Contract Development and Compliance |
| H. | Enrollee Information as described in Section 2-10.2.1 | Weekly, by Wednesday of the following week to TENNCARE, Information Systems Section |
| I. | Eligibility and Administrative Fee Payment reconciliation as described in Section 2-10.2.3 | Quarterly, by the 30 th of the following month to the TENNCARE Information Systems Section |
| J. | Enrollee Cost-Sharing in accordance with Section 2-10.2.4 | Quarterly, by the 30 th of the following month to TennCare Information Systems Section |
| K. | Provider Enrollment listing in accordance with Section 2-10.3.1 | Monthly, within five (5) working days following the end of the month, to the TennCare Information Systems Section |
| L. | Unduplicated listing of all providers and their unique identifying provider numbers cross-referenced to the Medicaid servicing provider number in accordance with Section 2-10.3.1 | Within ten (10) working days of a request by TENNCARE to the TennCare Information Systems Section |
| M. | Listing of Essential Hospital Providers in the MCO's provider network in accordance with Section 2-10.3.2 | By September 1 of each year to the Office of Fiscal Services |
| N. | Listing of Specialty Physician Arrangements in accordance with Section 2-10.3.2 | By September 1 of each year to the Office of Provider Networks |
| O. | Reporting Other Insurance in accordance with Section 2-10.4 | To be Determined |
| P. | Individual Encounter Reporting in accordance with 2-10.5 | Monthly, by the 15 th of the following month, to TENNCARE, Information Systems Section |
| Q. | Weekly Activity Reporting in | Weekly, by Wednesday of the following week to |

Amendment 1 (continued)

	accordance with Section 2-10.7	Office of Contract Development and Compliance
R.	Network Clearing House Reporting in accordance with Section 2-10.8	At TENNCARE's request
S.	Annual Report - Submitted on a form prescribed by the National Association of Insurance Commissioners in accordance with Section 2-10.9	Due on or before March 1 of each calendar year to The Department of Commerce and Insurance, TennCare Division
T.	Quarterly Financial Report - Submitted on a form prescribed by the National Association of Insurance Commissioners in accordance with Section 2-10.9	Due on or before June 1, September 1, and December 1 in accordance with Section 2-10.9 of this Agreement to be submitted to The Department of Commerce and Insurance, TennCare Division
U.	Audit of Business Transactions/ Audited Financial Statements in accordance with Section 2-10.9	Due on or before May 1 of each calendar year to The Department of Commerce and Insurance, TennCare Division
V.	Board of Directors in accordance with Section 2-10.10.3	At the beginning of the Agreement period and within ten (10) business days of a change to Office of Contract Development and Compliance
W.	Cost and Utilization Summaries in accordance with 2-10.11	As specified at 2-10.11
X	Cost and Utilization Reports in accordance with 2-10.11.8	As specified at 2-10.11.8
Y	Medical Fund Target Monitoring Report and supporting claims lag tables in accordance with 2-10.13	As specified at 2-10.3
Z	Network Management Reports in accordance with 2-9.4 and 2-10.15	As specified at 2-9.4 and 2-10.15
AA.	HIPAA Reporting in accordance with 2-4.10, 2-10.1, and 2-10.16	As specified at 2-10.16
BB.	QM Reports – Continuous Focused Studies in accordance with 2-10.14.1. and Attachment II	Within ninety (90) calendar days of the end of the calendar year to the Office of the TENNCARE Medical Director
CC.	QM Reports – Quarterly Focused Studies in accordance with 2-10.14.2 and Attachment II	Within thirty (30) calendar days of the end of the quarter to the Office of the TENNCARE Medical Director
DD.	QM Reports – Continuity of Care Reporting in accordance with 2-10.14.3 and Attachment II	Within thirty (30) calendar days of the end of the quarter to the Office of the TENNCARE Medical Director

Amendment 1 (continued)

EE.	All required QM/QI reports in accordance with 2-10 and Attachment II	As specified, to the office of the TENNCARE Medical Director
FF.	Written plan of changes resulting from monitoring and audit in accordance with Section 2-16	Within fifteen (15) working days after receipt of notice of deficiencies to the Office of Contract Development and Compliance, unless otherwise specified in the request from TENNCARE
GG.	Ownership and Financial Disclosure in accordance with Section 2-21	With Agreement, and annually thereafter by March 1 of every year to the Office of Contract Development and Compliance
HH.	Significant business transaction in accordance with Section 2-21	Upon Occurrence to the Department of Commerce and Insurance, TennCare Division
II.	Annual submission of personnel/operational policies that emphasize non-discrimination in hiring, promotional and contracting processes as described in Section 2-24	Annually, within ninety (90) calendar days after the end of the year to the Title VI compliance officer
JJ.	Quarterly listing of complaints/appeals filed alleging discrimination as described in Section 2-24	Quarterly, by the 30 th of the following month to the Title VI compliance officer
KK.	Quarterly listing of supervisory personnel as described in Section 2-24	Quarterly, by the 30 th of the following month to the Title VI compliance officer
LL.	Annual listing by CSA of non-institutional providers as described in Section 2-24	Annually, within ninety (90) calendar days after the end of the year to the Title VI compliance officer
MM	Annual copy of CONTRACTOR's policy regarding non-discrimination of services to persons with Limited English Proficiency as described in Section 2-24	Annually, within ninety (90) calendar days after the end of the year to the Title VI compliance officer
NN	On a Quarterly basis, a listing of all request of translation or interpreter services as described in Section 2-24.g.1.	Quarterly, by the 30 th of the following month to the Title VI compliance officer
OO	Annual Compliance Plan as described in Section 2-24	On an annual basis to the Title VI compliance officer

73. Part F. of Standard IX of Section I of Attachment II shall be deleted and replaced in its entirety so that the amended Part F. of Standard IX shall read as follows:

Amendment 1 (continued)

F. Process - The initial credentialing process obtains and reviews verification of the following information, at a minimum:

1. Primary Verification

- a. the practitioner holds a current valid license to practice within the State;
- b. valid DEA or CDS certificate, as applicable;
- c. confirmation of highest level of education and training received;
- d. professional liability claims history (past five (5) years) from the National Practitioner Data Bank and the State Board of Medical Examiners;
- e. any sanctions imposed by Medicare, Medicaid and/or TennCare;
- f. good standing of clinical privileges at the hospital designated by the practitioner as the primary admitting facility; (This requirement may be waived for practices which do not have or do not need access to hospitals.); and
- g. any revocation or suspension of a state license, DEA/BNDD number, or CDS certificate.

2. Secondary Verification (self reported)

- a. work history – past five (5) years. Verbal explanation for gaps greater than six (6) months, written explanation for gaps greater than one (1) year;
- b. the practitioner holds current, adequate malpractice insurance according to the plan's policy;
- c. any curtailment or suspension of medical staff privileges (other than for incomplete medical records);
- d. any censure by the State or County Medical Association;
- e. the application process includes a statement by the applicant and an investigation of said statement regarding:
 - (1) any physical or mental health problems that may affect current ability to provide health care;
 - (2) any history of chemical dependency/substance abuse;
 - (3) history of loss of license and/or felony convictions;
 - (4) history of loss or limitation of privileges or disciplinary activity; and
 - (5) current malpractice coverage and limits; and
 - (6) an attestation to correctness/completeness of the application.

Amendment I (continued)

This information should be used to evaluate the practitioner's current ability to practice.

3. There is an initial visit to each potential primary care practitioner's office, including documentation of a structured review of the site and medical record keeping practices to ensure conformance with the managed care organization's standards.

74. Part IV "Quality of Care Monitors" of Section IV of Attachment II shall be amended by deleting item number 9 in its entirety and replacing it with the following:

9. TennCare shall monitor MCO progress toward obtaining the benchmark level of performance for each of the measures specified below. The CONTRACTOR shall demonstrate meaningful improvement each year. Meaningful improvement is defined as obtaining the benchmark level of performance or demonstrating a ten (10) percentage point improvement, unless otherwise specified by TENNCARE over the MCOs prior years rate. The CONTRACTOR shall not be required to develop and analyze performance indicators for enrollees in Groups 3, 4, or 5 as defined in Section 4 of this Agreement. The performance indicators are:

Performance Indicator	Data Sources	Measure	Target	Benchmark
Childhood Immunizations	MCO encounter data; TennCare enrollment data	percentage of two-year old children receive all 12 recommended vaccines	100% of children immunized	90th percentile of the current year Medicaid HEDIS.
Adolescent Immunizations	MCO encounter data ;TennCare Enrollment data	percentage of enrolled adolescents (who turn 13 during measurement year) receive recommended vaccines	100% of adolescents immunized	90th percentile of the current year Medicaid HEDIS.
Checkups After Delivery	MCO encounter data ;TennCare enrollment data	percentage of female enrollees receive a post partum checkup 3-8 weeks after delivery	100% of women that delivery receive a check-up	90th percentile of the current year Medicaid HEDIS.
Cervical Cancer Screening	MCO encounter data; TennCare enrollment data	percentage of enrolled women (ages 21-64) receive one or more pap tests in the reporting year or the two years prior to the reporting year	According to ACOG guidelines	90th percentile of the current year Medicaid HEDIS.

Amendment 1 (continued)

Performance Indicator	Data Sources	Measure	Target	Benchmark
Breast Cancer Screening	MCO encounter data; TennCare enrollment data	percentage of enrolled women who received a mammogram in the past two years	According to ACOG guidelines	90th percentile of the current year Medicaid HEDIS.
HBA1c Testing	MCO encounter data; TennCare enrollment data	percentage of members age 18 through 75 with a diagnosis of diabetes, with one or more tests conducted during the measurement year. Notation in the medical record of any one of the following is acceptable: - Glycated hemoglobin - Glycosylated hemoglobin A1c - Glyco hemoglobin A1c - HBA1c hemoglobin A1c	At least one test each year	90th percentile of the current year Medicaid HEDIS.
EPSDT	MCO encounter data; TennCare enrollment data	The percentage of children who received a periodic screen including all components (consistent with EPSDT Consent Decree Definition)	100% screening	Adjusted periodic screening percentage greater than 80%

For the purpose of monitoring Quality of Care, Access to Care and Availability of Care, TennCare shall routinely review vital records, birth records, individual encounter data, monthly provider files and other required reports to monitor quality of care and other available sources. TennCare may use individual encounter data, monthly provider files and other required reports to measure the Managed Care Organization's compliance with Provider Network, Claims Processing, Financial/Actuarial Stability, Clinical/Quality and Member/Provider Service standards.

75. Attachment IV shall be deleted and replaced in its entirety and the amended Attachment IV shall be attached to the end of this Amendment.
76. Attachment IX shall be deleted in its entirety and labeled "This Attachment Deleted Intentionally".

Amendment 1 (continued)

77. Attachment XI shall be deleted in its entirety and replaced by a new Attachment XI which shall be attached to the end of this Amendment.
78. The "Pharmacy Specific" requirements of Attachment XII, Exhibit G shall be amended by deleting the reference to "Prescribing Provider Number" and replacing it with "Prescribing Provider's DEA Number".
79. Attachment XII shall be amended by deleting the existing Exhibit L and replacing it with a new Exhibit L which shall be attached to the end of this Amendment.
80. Attachment XII shall be amended by adding a new Exhibit M which shall be attached to the end of this Amendment.
81. Attachment XII shall be amended by adding a new Exhibit N which shall be attached to the end of this Amendment.

ATTACHMENT IV – SPECIALTY NETWORK STANDARDS

**ATTACHMENT IV
Specialty Network Standards**

For the purpose of assessing specialty provider network adequacy, TennCare MCO networks will be evaluated relative to the requirements described below. The purpose of these requirements is to ensure access and availability to specialists for non-dual Medicare/Medicaid eligibles while recognizing the actual disbursement and number of specialty resources available within the state. A provider is considered a “specialist” if he/she has a provider agreement with the MCO to provide specialty services to enrollees.

Access to Specialty Care

Contractors shall ensure access to specialists for the provision of covered services. This requirement shall be satisfied through the execution and maintenance of at least one provider agreement for the provision of each of the following types of specialist services in the area specified. This requirement ensures that TennCare enrollees in all MCOs will be able to access specialists within the community in which they reside or as close to it as feasible, while recognizing the constraints introduced by the limited availability of specialists in some areas.

The geographic areas, or “focal points” where contracts are required include Davidson, Hamilton, Knox, Madison, Maury, Putnam and Cumberland (Either one), Shelby, and Sullivan and Washington (Either one) counties, either because these are population centers or there is a major medical center located in the area. If MCOs establish contracts for the provision of specialty services in each of these eight focal points all TennCare enrollees will have access to specialists within a maximum travel distance of 90 miles, and the majority will have access to specialists within 60-miles. Contracts are required in these specific areas in recognition of traditional specialty referral patterns.

The areas in which MCOs are required to establish contracts are indicated in the chart below by Grand Region. Based on these requirements, an MCO serving the East Grand Region would be required to have at least three Cardiologists in its network (one in Hamilton, One in Knox, and one in Sullivan or Washington counties).

SPECIALIST	GRAND REGION		
	WEST	MIDDLE	EAST
Cardiology	<ul style="list-style-type: none"> ▪ Madison ▪ Shelby 	<ul style="list-style-type: none"> ▪ Davidson ▪ Putnam/Cumberland ▪ Maury 	<ul style="list-style-type: none"> ▪ Hamilton ▪ Knox ▪ Sullivan/Washington
Otolaryngology	<ul style="list-style-type: none"> ▪ Madison ▪ Shelby 	<ul style="list-style-type: none"> ▪ Davidson ▪ Putnam/Cumberland ▪ Maury 	<ul style="list-style-type: none"> ▪ Hamilton ▪ Knox ▪ Sullivan/Washington
Gastroenterology	<ul style="list-style-type: none"> ▪ Madison ▪ Shelby 	<ul style="list-style-type: none"> ▪ Davidson ▪ Putnam/Cumberland* ▪ Maury* 	<ul style="list-style-type: none"> ▪ Hamilton ▪ Knox ▪ Sullivan/Washington
Neurology	<ul style="list-style-type: none"> ▪ Madison ▪ Shelby 	<ul style="list-style-type: none"> ▪ Davidson ▪ Putnam/Cumberland* ▪ Maury* 	<ul style="list-style-type: none"> ▪ Hamilton ▪ Knox ▪ Sullivan/Washington

SPECIALIST	GRAND REGION		
	WEST	MIDDLE	EAST
Neurosurgery	<ul style="list-style-type: none"> ▪ Shelby <p>Not Applicable to Madison</p>	<ul style="list-style-type: none"> ▪ Davidson <p>Not Applicable to Putnam/Cumberland and Maury</p>	<ul style="list-style-type: none"> ▪ Hamilton ▪ Knox <p>Not Applicable to Sullivan/Washington</p>
Oncology/Hematology	<ul style="list-style-type: none"> ▪ Madison ▪ Shelby 	<ul style="list-style-type: none"> ▪ Davidson ▪ Putnam/Cumberland* ▪ Maury* 	<ul style="list-style-type: none"> ▪ Hamilton ▪ Knox ▪ Sullivan/Washington
Ophthalmology	<ul style="list-style-type: none"> ▪ Madison ▪ Shelby 	<ul style="list-style-type: none"> ▪ Davidson ▪ Putnam/Cumberland ▪ Maury 	<ul style="list-style-type: none"> ▪ Hamilton ▪ Knox ▪ Sullivan/Washington
Orthopedics	<ul style="list-style-type: none"> ▪ Madison ▪ Shelby 	<ul style="list-style-type: none"> ▪ Davidson ▪ Putnam/Cumberland ▪ Maury 	<ul style="list-style-type: none"> ▪ Hamilton ▪ Knox ▪ Sullivan/Washington
Urology	<ul style="list-style-type: none"> ▪ Madison ▪ Shelby 	<ul style="list-style-type: none"> ▪ Davidson ▪ Putnam/Cumberland ▪ Maury* 	<ul style="list-style-type: none"> ▪ Hamilton ▪ Knox ▪ Sullivan/Washington

Availability of Specialty Care

Contractors shall provide adequate numbers of specialists for the provision of covered services to ensure adequate provider availability. To account for variances in MCO enrollment size, the guidelines described in this section have been established for determining how many of each type of specialist an MCO must have. These are aggregate guidelines and are not age specific. To determine these guidelines the number of providers within each of the focal points in each Grand Region was compared to the size of the population in each Grand Region. The “area” being served includes the population of surrounding counties. The chart below provides the mapping of counties to focal points.

MCOs must comply with the following guidelines: MCOs must have at least one provider agreement with each specialist in each required area; and, MCOs must have a sufficient number of provider agreements to ensure that the number of enrollees per provider does not exceed the following:

Maximum Number of Non-Dual Enrollees per Provider by Specialty and Focal Point

Grand Region	Cardiology	Otolaryngology	Gastroenterology	Neurology	Neurologic Surg	Ophthalmology	Orthopedic Surg	Oncology/Hematology	Urology
EAST	19,000	45,000	29,500	40,000	53,500	21,500	14,500	75,500	43,500
MIDDLE	22,000	36,000	47,500	35,000	57,500	22,000	17,500	108,500	33,500
WEST	18,800	26,000	29,500	27,000	27,000	15,500	12,000	85,000	23,000

Monitoring

TennCare will monitor MCO compliance with specialist network standards on an on-going basis. Data from the monthly provider file will be used to verify compliance with the specialty network requirements. This file will serve as the source for confirming the MCO has a sufficient number and distribution of specialists and for calculating enrollee to provider ratios. TennCare will also phone providers listed on this file periodically to confirm that the provider is under contract to provide specialty services as reported by the MCO. Appeals data will also be monitored for indications that problems exist with access to specialists, and corrective action plans will be required when appropriate.

ATTACHMENT IX – THIS ATTACHMENT LEFT BLANK INTENTIONALLY

ATTACHMENT XI - COST SHARING SCHEDULES

**ATTACHMENT XI
Cost-Sharing Schedules**

1. Out-of-Pocket Expenditures effective prior to January 1, 2003

The TENNCARE deductible for children, individuals and families shall be \$0.00. The annual TENNCARE maximum out-of-pocket expenditures described below shall apply for both uninsured and uninsurable designations for all covered TennCare services.

Poverty Level	Individual Maximum Annual Out-of-Pocket	Family Maximum Annual Out-of-Pocket
0%-100%	\$0.00	\$0.00
101% - 199%	\$1,000.00	\$2,000.00
200% and above	\$2,000.00	\$4,000.00

2. Out-of-Pocket Expenditures effective January 1, 2003

(a) **TennCare Standard enrollees have a maximum out-of-pocket expenditure for all services, including pharmacy. This amount is calculated per calendar year.**

- i. For enrollees in families with incomes equal to or above two hundred (200%) percent of the poverty level, the annual out-of-pocket maximum is two thousand (\$2,000) dollars per individual and four thousand (\$4,000) dollars per family.
- ii. For enrollees in families with incomes below two hundred (200%) percent of the poverty level, the annual out-of-pocket maximum is one thousand (\$1,000) dollars per individual and two thousand (\$2,000) dollars per family.
- iii. Included in the annual out-of-pocket maximums are monthly out-of-pocket maximums for pharmacy services only. The monthly out-of-pocket maximum for pharmacy services for all TennCare Standard enrollees is one hundred-fifty (\$150.00) dollars per enrollee per month. This copayment is included in the calculation to reach the total annual out-of-pocket expenditures.

(b) TennCare Medicaid enrollees shall be required to pay a copayment for prescription medications, as described below. Excluded from this requirement are children enrolled in TennCare Medicaid and long-term care residents.

2. Copayments prior to January 1, 2003:

The following TENNCARE copayment schedule shall apply for both Uninsured and Uninsurable designations, based on the poverty level specified in TENNCARE rule 1200-13-12-.05(1)(c):

Poverty Level	Copayment Amounts
0%-100%	\$0.00
101% - 199%	\$25.00, Hospital Emergency Room (waived if admitted) \$5.00, Primary Care Provider and Community Mental Health

Amendment 1 (continued)

	Agency Services Other Than Preventive Care \$15.00, Physician Specialists \$5.00, Prescription or Refill \$100.00, Inpatient Hospital Admission
200% and above	\$50.00, Hospital Emergency Room (waived if admitted) \$10.00, Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care \$25.00, Physician Specialists \$10.00, Prescription or Refill \$200.00, Inpatient Hospital Admission

3. Copayments effective January 1, 2003:

The CONTRACTOR is specifically prohibited from waiving or discouraging TENNCARE enrollees from paying the amounts described in this provision.

- (a) Effective January 1, 2003, copayment amounts for TennCare Standard enrollees with incomes equal to or above 100% of the poverty level will be:

Inpatient Hospital Admission	\$100.00 per admission
Emergency Room (An enrollees shall not be charged this amount if s/he is admitted to the hospital).	\$25.00 per visit
Physician Primary Care Physician (PCP) Physician Specialists (Not applicable to preventive services).	\$10.00 per visit \$15.00 per visit
Annual eye exam for individuals under age 21 (Not a covered service for adults age 21 and over.)	\$10.00 per visit
Home Health Services	\$10.00 per visit
Speech Therapy	\$10.00 per visit
Hospitalization related to organ transplant	See Inpatient Hospitalization
Hospitalization related to reconstructive breast surgery	See Inpatient Hospitalization
Pharmacy	Generic drugs for which there is more than one source: \$5.00 A brand name drug for which there is only one source: \$15.00 A brand name drug which is available from more than one source: \$25.00

Amendment 1 (continued)

- (b) Effective January 1, 2003, copayment amounts for TennCare Standard enrollees with incomes less than one hundred (100%) percent of the poverty level shall be limited to pharmacy and will be:

Pharmacy	Generic drugs for which there is more than one source.\$1.00
	A brand name drug for which there is only one source.\$3.00
	A brand name drug which is available from more than one source.\$5.00

- (c) Effective January 1, 2003, TennCare Medicaid enrollees shall be required to pay a copayment for prescription medications, as described below. Excluded from this requirement are children enrolled in TennCare Medicaid and long-term care residents.

Pharmacy	Generic drugs for which there is more than one source.\$1.00
	A brand name drug for which there is only one source.\$1.00
	A brand name drug which is available from more than one source.\$3.00

ATTACHMENT XII, EXHIBIT J.1
Instructions for Completing the Medical Fund Monitoring Report

The purpose of this report is to compare payments made to providers by the managed care organization ("MCO") on a date of service incurred basis with the Medical Fund Target established by TennCare by Grand Region and in Total. The MCO will submit this report monthly, due by the 21st of the following month. The MCO will also file this report with its NAIC filings due in March and September of each year using an accrual basis that includes incurred but not reported amounts by calendar service period that have been certified by an actuary. This report must reconcile to NAIC filings. A letter shall accompany this report from an actuary indicating that the reports, including the estimate for incurred but not reported expenses, have been reviewed for accuracy. A printed copy and electronic version of the report is to be submitted to the following:

Keith Gaither
Chief Financial Officer
Bureau of TennCare
Department of Finance and Administration
P. O. Box 593
Nashville, TN 37202-0593

John R. Mattingly
TennCare Examinations Manager
Department of Commerce and Insurance
TennCare Division
500 James Robertson Parkway, Suite 750
Nashville, TN 37243-1169

Email: kgaither@mail.state.tn.us

Email: jmattingly@mail.state.tn.us

Instructions for completing the report:

- Enter the MCO name.
- Enter the reporting month.
- Enter the monthly number of **TennCare enrollees**.
- Report the monthly amount of the **Medical Fund Target received from TennCare**.
- Aggregate payments by **Grand Region** based on enrollee residence.
- Each month report the amount of **Payments for Medical Services** made as of the effective date of the Agreement for services incurred through the end of the report month on a cumulative calendar year to date basis. For example, if the effective date of the Agreement is July 1, 2001, the Monthly Medical Loss Report for the month of August 2001 shall include all payments made for services incurred after July 1, 2001 through August 31, 2001. Payments made for services incurred prior to July 1, 2001 must be excluded. Thereafter, reporting will be on a calendar year basis.
- Report the amount of **Payments by the Claims Processing System** made for **UB92, HCFA1500, and dental** claim types in the appropriate supporting triangle lag reports. The amounts entered into the triangle lag reports will automatically be reported in the appropriate incurred month by the Excel spreadsheet. The CONTRACTOR shall report the amount of claims processed prior to the effective date of this Agreement by month in order to clearly delineate payment for services made prior to July 1, 2001. If a subcontractor processes dental and/or other services then these payments should be reported on the Subcontractor Payments for Medical Services line and not entered into the triangle lag report.

Amendment I (continued)

- Report for each month the total amount of **Capitation Payments**. Capitation payments should include payments made directly to a service provider on a capitated basis.
- Report for each month the total amount of **Pharmacy Payments**.
- Report for each month the total amount of **Subcontractor Payments for Medical Services**. Subcontract payments should include payments made for services that are coordinated or arranged by a subcontractor.
- Report for each month the total amount of **Reinsurance Payments**. Reinsurance payments are payments made to a licensed or authorized reinsurer to limit medical and hospital expenses by reducing maximum expenses on an individual basis, on an aggregate basis, or both.
- Report for each month the total amount of **Other Payments/Adjustments to Medical Costs**. Other payments may include settlements and claims payments made outside the claims processing system. Other payments/adjustments made for services incurred prior to July 1, 2002 must be excluded.
- Report for each month the total amount of **Pharmacy Rebates** received. Rebates may be received quarterly and should be allocated on a reasonable monthly basis for pharmacy services incurred July 1, 2002 and subsequent.
- Report for each month the total amount of **Recoveries not Reflected in Payments by the Claims System**. Recoveries may include reinsurance payments, subrogation payments, and other settlement payments received.
- The Excel spreadsheet calculates the **Total Payments for the Month**.
- Report the **Remaining IBNR for the Month**. The remaining IBNR is the estimated amount to be paid for services incurred through the report month but not yet reported. IBNR should not include estimated bonus payments, unless specifically accounted for in the provider's contract. A brief explanation of the IBNR estimate should be attached.
- The Excel spreadsheet calculates the **Medical Services Payments and Remaining IBNR for the Month**.
- The Excel spreadsheet calculates the **Medical Loss Ratio** as Total Medical Services Payments and Remaining IBNR divided by the Medical Fund Target.

MEDICAL FUND MONITORING REPORT
GRAND REGION

2002												
Incurred Month												
	January	February	March	April	May	June	July	August	September	October	November	December
the Month												
g System	0	0	0	0	0	0	0	0	0	0	0	0
essing System	0	0	0	0	0	0	0	0	0	0	0	0
g System	0	0	0	0	0	0	0	0	0	0	0	0
vices												
	0	0	0	0	0	0	0	0	0	0	0	0
the month	0	0	0	0	0	0	0	0	0	0	0	0

ATTACHMENT XII, EXHIBIT L – COST AND UTILIZATION REPORTING

[MCO NAME]
 Cumulative Year to Date
 By Grand Region
 Cost & Utilization Report
 Incurred Period: XX/XX/XXXX – XX/XX/XXXX
 Paid Through XX/XX/XXXX

Managed Care Metrics	VID % Changes	[MCO] Total	Medicaid Adult	Medicaid Child	Uninsured Adult	Uninsured Child	Medically Eligible Adult	Medically Eligible Child	Disabled Adult	Disabled Child	Duals
Cumulative Member Months											
Member Months											
Total Claims Health Care Expense											
Classified Health Care Expense											
Inpatient											
Outpatient											
Total Practitioner R.A.P. – Hospital Based											
Primary Care											
Specialist											
Total Pharmacy											
Total Miscellaneous Transportation											
Total Capitation											
Vendor A											
Vendor B											
Vendor C											
Vendor D											
Vendor E											

[MCO NAME]
 Cumulative Year to Date
 By Grand Region
 Inpatient Report
 Incurred Period: XX/XX/XXXX – XX/XX/XXXX
 Paid Through XX/XX/XXXX

Managed Care Metrics	YTD % Changes	[MCO] Total	Medicaid Adult	Medicaid Child	Uninsured Adult	Uninsured Child	Medically Eligible Adult	Medically Eligible Child	Disabled Adult	Disabled Child	Duals
Cumulative Member Months											
Member Months											
Total Inpatient											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											
Average Length of Stay											
Medical											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											
Average Length of Stay											
Surgical											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											
Average Length of Stay											
Obstetrical											
Payment Per Admission											
Payment Per Day											
Payment PMPM											
Admission per 1,000											
Days per 1,000											
Average Length of Stay											

[MCO NAME]
 Cumulative Year to Date
 By Grand Region
 Outpatient Report
 Incurred Period: XX/XX/XXXX - XX/XX/XXXX
 Paid Through XX/XX/XXXX

Managed Care Metrics	YTD % Change	MCO Total	Medicaid Adult	Medicaid Child	Uninsured Adult	Uninsured Child	Medically Eligible Adult	Medically Eligible Child	Disabled Adult	Disabled Child	Duals
Cumulative Member Months											
Member Months											
Total Outpatient											
Payment Per Visit											
Payment PMPM											
Visits per 1,000											
Surgery											
Payment Per Visit											
Payment PMPM											
Visits per 1,000											
ER-Emergency											
Payment Per Visit											
Payment PMPM											
Visits per 1,000											
ER-Non-Emergency											
Payment Per Visit											
Payment PMPM											
Visits per 1,000											
Diagnostic											
Payment Per Visit											
Payment PMPM											
Visits per 1,000											
Other Services											
Payment Per Visit											
Payment PMPM											
Visits per 1,000											

[MCO NAME]
 Cumulative Year to Date
 By Grand Region
 Practitioner Report
 Incurred Period: XX/XX/XXXX – XX/XX/XXXX
 Paid Through XX/XX/XXXX

Managed Care Metrics	YTD % Changes	[MCO] Total	Medicaid Adult	Medicaid Child	Uninsured Adult	Uninsured Child	Medically Eligible Adult	Medically Eligible Child	Disabled Adult	Disabled Child	Duals
Cumulative Member Months											
Member Months											

Payment PMPM											
Total Practitioner											
Radiology											
Anesthesiology											
Pathology											
Total R.A.P.											
Primary Care Adult											
Primary Care Child											
Primary Care Total											
OB-GYN											
Cardiology											
Gastroenterology											
General Surgery											
Hematology/Oncology											
Neurology											
Orthopedic Surgery											
Pulmonology											
Ophthalmology/Optometry											
Otolaryngology											
Urology											
Emergency Medicine											
Other											
Total Specialist											
Total Primary & Specialty											

Visits Per 1,000											
Total Practitioner											
Radiology											
Anesthesiology											
Pathology											
Total R.A.P.											
Primary Care Adult											

Amendment 1 (continued)

Managed Care Metrics	YTD % Changes	[MCO] Total	Medicaid Adult	Medicaid Child	Uninsured Adult	Uninsured Child	Medically Eligible Adult	Medically Eligible Child	Disabled Adult	Disabled Child	Duals
Primary Care Child											
Primary Care Total											
OB-GYN											
Cardiology											
Gastroenterology											
General Surgery											
Hematology/Oncology											
Neurology											
Orthopedic Surgery											
Pulmonology											
Ophthalmology/Optometry											
Otolaryngology											
Urology											
Emergency Medicine											
Other											
Total Specialist											
Total Primary & Specialty											

[MCO NAME]
 Cumulative Year to Date
 By Grand Region
 Pharmacy Report
 Incurred Period: XX/XX/XXXX – XX/XX/XXXX
 Paid Through XX/XX/XXXX

Managed Care Metrics	YTD % Changes	MCO Total	Medicaid Adult	Medicaid Child	Uninsured Adult	Uninsured Child	Medically Eligible Adult	Medically Eligible Child	Disabled Adult	Disabled Child
Cumulative Member Months										
Member Months										
Pharmacy Total										
Ingredient Cost Per Script										
Payment Per Script										
Payment PMPM										
Scripts PMPM										
Annualized Scripts Per 1,000										
Brand										
Payment per Script										
Payment PMPM										
Scripts PMPM										
% Brand Utilization										
% Brand Costs										
Generic										
Payment Per Script										
Payment PMPM										
Scripts PMPM										
% Generic Utilization										
% Generic Costs										

[MCO NAME]
 Cumulative Year to Date
 By Grand Region
 Miscellaneous Report
 Incurred Period: XX/XX/XXXX – XX/XX/XXXX
 Paid Through XX/XX/XXXX

Managed Care Metrics	YTD % Changes	[MCO] Total	Medicaid Adult	Medicaid Child	Uninsured Adult	Uninsured Child	Medically Eligible Adult	Medically Eligible Child	Disabled Adult	Disabled Child	Duals
Cumulative Member Months											
Member Months											
Total Miscellaneous											
Payment PMPM											
Durable Medical Equipment											
Payment PMPM											
Cost Per Unit											
Utilization per 1000											
Home Infusion Therapy											
Payment PMPM											
Cost Per Unit											
Utilization per 1000											
Home Health Agency											
Payment PMPM											
Cost Per Unit											
Utilization per 1000											
Orthotics/Prosthetics											
Payment PMPM											
Cost Per Unit											
Utilization per 1000											
Vision Hardware											
Payment PMPM											
Cost Per Unit											

Amendment I (continued)

Managed Care Metrics	YTD % Changes	[MCO] Total	Medicaid Adult	Medicaid Child	Uninsured Adult	Uninsured Child	Medically Eligible Adult	Medically Eligible Child	Disabled Adult	Disabled Child	Duals
Utilization per 1000											
Transportation											
Payment PMPM											
Cost Per Unit											
Utilization per 1000											
Other											
Payment PMPM											
Cost Per Unit											
Utilization per 1000											

**ATTACHMENT XII, EXHIBIT M – ELIGIBILITY AND PREMIUM RECONCILIATION
REPORTING**

**ATTACHMENT XII, EXHIBIT M.1
ELIGIBILITY AND PREMIUM RECONCILIATION SUMMARY REPORT**

**<INSERT MCO NAME>
SUMMARY REPORT
For the Quarter Ended <INSERT DATE >**

<u>Report Title:</u>	Members	Over (Under) Paid
Premium Discrepancy Report	5	\$ (419.61)
No Premium Report	2	(282.70)
No Eligibility Report	2	535.68
Total	<u>9</u>	<u>\$ (166.63)</u>

Note: The first row of member detail on each report provides the detail the MCO has on file, based on information from eligibility tapes received from the State. This row also includes a calculation of the amount of premium expected. The second row (State Info) details the premium actually received from the State, per the monthly premium tape.

Report Definitions

Calculated Age	The age of the member is calculated based on the Start Date, per the premium tape received from the State, less the member's Date of Birth, per the eligibility information maintained by the MCO based on the eligibility tapes received. Neither the member's age nor the Date of Birth are on the premium tape.
MCO Effective Date	The date the MCO has the member effective. The source of this information is the eligibility tape received from the State.
MCO Term Date	The date the MCO has the member terminated. The source of this information is the eligibility tape received from the State.
State Start Date	The starting date for which the State is paying premiums, per the premium tape received from the State.
State End Date	The ending date for which the State is paying premiums, per the premium tape received from the State.
Amount Expected	The expected amount of premium to be paid per reporting period, based upon eligibility information.

ATTACHMENT XII, EXHIBIT M.2

ELIGIBILITY AND PREMIUM RECONCILIATION PREMIUM DESCREPANCY REPORT

<INSERT MCO NAME>
PREMIUM DISCREPANCY REPORT
 For the Quarter Ended **<INSERT DATE >**

										Amount	
MCO Info	Member Name	ID	Date of Birth	Calc. Age	Sex	CSA	Program Code	Effective Date	Term Date	Expected	Over (Under)
State Info	Member Name	ID	Date of Birth	Calc. Age	Sex	CSA	Program Code	Start Date	End Date	Received	Paid
	Smith, John	444-33-1111	08/24/66	34	M	2	87	8/1/01	8/31/01	\$ 96.40	
	Smith, John	444-33-1111			M	2	17	8/1/01	8/31/01	14.84	\$ (81.56)
	Smith, Jane	444-33-2222	02/13/67	33	F	2	67	7/1/00	12/31/99	714.54	
	Smith, Jane	444-33-2222			F	2	67	7/1/01	8/15/01	357.27	(357.27)
	Jones, Alice	444-33-3333	06/25/57	44	F	4	87	7/1/01	12/31/99	475.41	
	Jones, Alice	444-33-3333			F	4	87	7/1/01	9/30/01	899.10	423.69
	Jones, Steve	444-33-4444	09/30/72	28	M	3	97	8/1/01	12/31/99	508.04	
	Jones, Steve	444-33-4444			M	4	97	8/1/01	9/30/01	501.76	(6.28)
	Robertson, Pat	444-33-5555	11/11/76	22	F	1	67	4/1/99	12/31/99	682.08	
	Robertson, Pat	444-33-5555			M	1	67	7/1/01	9/30/01	283.89	(398.19)

ATTACHMENT XII, EXHIBIT M.3

ELIGIBILITY AND PREMIUM RECONCILIATION NO PREMIUM REPORT

<INSERT MCO NAME>
NO PREMIUM REPORT
 For the Quarter Ended **<INSERT DATE >**

											Amount	
MCO Info	Member Name	ID	Date of Birth	Calc. Age	Sex	CSA	Program Code	Start Date	End Date	Expected	Over (Under)	
State Info	Member Name	ID	Date of Birth	Calc. Age	Sex	CSA	Program Code	Start Date	End Date	Received	Paid	
	Doe, John	555-44-3333	09/29/39	54	M	2	17	1/1/94	12/31/99	\$ 44.52		
	-	-			-	-	-	-	-	0.00	\$ (44.52)	
	Doe, Jane	555-44-4444	01/18/52	49	F	2	67	9/1/01	9/30/01	238.18		
	-	-			-	-	-	-	-	0.00	(238.18)	

Amendment 1 (continued)

ATTACHMENT XII, EXHIBIT M.4

ELIGIBILITY AND PREMIUM RECONCILLIATION NO ELIGIBILITY REPORT

<INSERT MCO NAME>
NO ELIGIBILITY REPORT
 For the Quarter Ended **<INSERT DATE >**

											Amount	
MCO Info	Member Name	ID	Date of Birth	Calc. Age	Sex	CSA	Program Code	Start Date	End Date	Expected	Over (Under)	
State Info	Member Name	ID	Date of Birth	Calc. Age	Sex	CSA	Program Code	Start Date	End Date	Received	Paid	
-	-	-	-	-	-	-	-	-	-	\$ 0.00		
	Jones, John	777-66-5555			M	1	67	7/1/01	7/31/01	94.63	\$ 94.63	
-	-	-	-	-	-	-	-	-	-	0.00		
	Jones, Jane	777-66-6666			F	3	97	7/1/01	7/31/01	441.05	441.05	

Amendment 1 (continued)

ATTACHMENT XII, EXHIBIT N – MONTHLY DCS INVOICE

VOLUNTEER STATE HEALTH PLAN, INC.

CUMULATIVE BILLING SUMMARY FOR DCS CHILDREN NOT TENNCARE ELIGIBLE

For the Period _____, Through _____, with Information Received Through _____

Month	Claims Paid	Number of Members Termed	Administrative Fee	Amount Received	Amount Due
January	\$ -	2	\$ 87.36	\$ -	\$ 87.36
February	-	8	349.44	-	349.44
March	-	9	393.12	-	393.12
April	-	25	1,092.00	-	1,092.00
May	-	31	1,354.08	-	1,354.08
June	-	24	1,048.32	-	1,048.32
June	-	28	1,223.04	-	1,223.04
Total	\$ -	127	\$ 5,547.36	\$ -	\$ 5,547.36
Net Due					\$ 5,547.36

Claims Paid

Represents claim paid during the month noted. A detail report by date of service and date paid is also attached. These claims have already been paid and, as such, the total represents the amount DCS needs to reimburse the Bureau of TennCare.

Number of Members Termed

Represents a count of the number of members whose eligibility termed during the noted month.

Administrative Fee

The agreed upon flat administrative fee owed for each unique member span.

Net Due

Current amount of Administrative Fee owed to VSHP. (Administrative Fee less Amount Received)

VOLUNTEER STATE HEALTH PLAN, INC.
CLAIMS PAID FOR DCS CHILDREN NOT TENNCARE ELIGIBLE

For the Period _____, Through _____, with Information Received Through _____

Paid Month	Date of Service Month												Total				
	January 2003	February 2003	March 2003	April 2003	May 2003	June 2003	July 2003	August 2003	September 2003	October 2003	November 2003	December 2003					
January 2003 \$	-																\$
February 2003 \$	-	\$	-														\$
March 2003 \$	-	\$	-	\$	-												\$
April 2003 \$	-	\$	-	\$	-	\$	-										\$
May 2003 \$	-	\$	-	\$	-	\$	-	\$	-								\$
June 2003 \$	-	\$	-	\$	-	\$	-	\$	-	\$	-						\$
July 2003 \$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-				\$
August 2003 \$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-		\$
September 2003 \$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	\$
October 2003 \$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	\$
November 2003 \$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	\$
December 2003 \$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	\$
\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	\$

Amendment I (continued)

VOLUNTEER STATE HEALTH PLAN, INC.
ADMINISTRATIVE FEE FOR DCS CHILDREN NOT TENNCARE ELIGIBLE

For the Period _____, Through _____, with Information Received Through _____

Member Number	Member Name	Effective Date	Term Date	01	02	03	04	05	06	07	Month	Total Days	Administrative Fee
3456885		06/26/2002	07/02/2002	0	0	0	0	0	5	2	200207	7	43.68
3456886		04/12/2002	04/16/2002	0	0	0	5	0	0	0	200204	5	43.68
3456887		04/26/2002	04/30/2002	0	0	0	5	0	0	0	200204	5	43.68
3456888		05/23/2002	05/27/2002	0	0	0	0	5	0	0	200205	5	43.68
3456889		05/23/2002	05/27/2002	0	0	0	0	5	0	0	200205	5	43.68
3456890		02/08/2002	02/11/2002	0	4	0	0	0	0	0	200202	4	43.68
3456891		02/19/2002	02/22/2002	0	4	0	0	0	0	0	200202	4	43.68
3456892		05/20/2002	05/23/2002	0	0	0	0	4	0	0	200205	4	43.68
3456893		06/21/2002	06/24/2002	0	0	0	0	0	4	0	200206	4	43.68
3456894		06/21/2002	06/24/2002	0	0	0	0	0	4	0	200206	4	43.68
3456895		06/21/2002	06/24/2002	0	0	0	0	0	4	0	200206	4	43.68
3456896		06/21/2002	06/24/2002	0	0	0	0	0	4	0	200206	4	43.68
3456897		02/05/2002	02/07/2002	0	3	0	0	0	0	0	200202	3	43.68
3456898		02/05/2002	02/07/2002	0	3	0	0	0	0	0	200202	3	43.68
3456899		02/11/2002	02/13/2002	0	3	0	0	0	0	0	200202	3	43.68
3456900		03/18/2002	03/20/2002	0	0	3	0	0	0	0	200203	3	43.68
3456901		03/22/2002	03/24/2002	0	0	3	0	0	0	0	200203	3	43.68
3456902		04/05/2002	04/07/2002	0	0	0	3	0	0	0	200204	3	43.68
3456903		04/22/2002	04/24/2002	0	0	0	3	0	0	0	200204	3	43.68
3456904		05/31/2002	06/02/2002	0	0	0	0	1	2	0	200206	3	43.68
3456905		01/30/2002	01/31/2002	2	0	0	0	0	0	0	200201	2	43.68
3456906		03/17/2002	03/18/2002	0	0	2	0	0	0	0	200203	2	43.68
3456907		04/29/2002	04/30/2002	0	0	0	2	0	0	0	200204	2	43.68
3456908		04/30/2002	05/01/2002	0	0	0	1	1	0	0	200205	2	43.68
3456909		05/20/2002	05/21/2002	0	0	0	0	2	0	0	200205	2	43.68
3456910		03/12/2002	03/12/2002	0	0	1	0	0	0	0	200203	1	43.68
3456911		03/19/2002	03/19/2002	0	0	1	0	0	0	0	200203	1	43.68
3456912		06/22/2002	06/22/2002	0	0	0	0	0	1	0	200206	1	43.68
3456913		07/17/2002	07/17/2002	0	0	0	0	0	0	1	200207	1	43.68
3456914		07/23/2002	07/23/2002	0	0	0	0	0	0	1	200207	1	43.68
3456915		07/31/2002	07/31/2002	0	0	0	0	0	0	1	200207	1	43.68
127	Total			54	300	703	939	1,038	821	426	-	4,281	\$ 5,547.3

VOLUNTEER STATE HEALTH PLAN, INC.
CLAIMS LISTING FOR DCS CHILDREN NOT TENNCARE ELIGIBLE

For the Period _____, Through _____, with Information Received Through _____

Member Number	Member Name	Claim Number	Begin Date of Service	End Date of Service	Paid Date	DOS Month	Pd Month	Paid Amount
123456789	JONES, JOE	02168N077169	03/06/2002	03/06/2002	06/21/2002	3	6	\$ -
		02168U007242	03/06/2002	03/06/2002	06/21/2002	3	6	-
123456790	BROWN, SAM	02066U040570	03/01/2002	03/01/2002	03/15/2002	3	3	108.18
		02077N008544	03/01/2002	03/01/2002	03/22/2002	3	3	78.57
		02078N006413	03/01/2002	03/01/2002	03/29/2002	3	3	16.65
		020590710377438	03/02/2002	03/02/2002	03/22/2002	3	3	8.95
		020590755202982	03/02/2002	03/02/2002	03/22/2002	3	3	12.59
123456791	WHITE, MARY	02093N002639	03/06/2002	03/06/2002	04/12/2002	3	4	116.19
		02137N003649	03/11/2002	03/11/2002	05/24/2002	3	5	60.00
		02137U033675	03/11/2002	03/11/2002	05/24/2002	3	5	17.24
		02143N069095	05/22/2002	05/22/2002	05/31/2002	5	5	84.69
		020990585536050	04/25/2002	04/25/2002	05/17/2002	4	5	38.70
		02136M002811	04/19/2002	04/19/2002	05/24/2002	4	5	108.24
		020990963576972	04/29/2002	04/29/2002	05/17/2002	4	5	14.34
		02154V014395	05/12/2002	05/12/2002	06/14/2002	5	6	33.00
		021190314961016	05/21/2002	05/21/2002	06/14/2002	5	6	8.42
		02192T202200	07/02/2002	07/02/2002	07/19/2002	7	7	49.88
		02066U026597	02/16/2002	02/17/2002	03/15/2002	2	3	121.84
		02176N094014	02/16/2002	02/16/2002	07/05/2002	2	7	51.03
		02155N044599	02/17/2002	02/17/2002	06/14/2002	2	6	9.37
		02133T211365	04/24/2002	04/24/2002	05/24/2002	4	5	139.84
		02130T204022	04/30/2002	04/30/2002	05/17/2002	4	5	101.00
		02098N064388	03/19/2002	03/19/2002	04/12/2002	3	4	146.97
		021491222144351	07/11/2002	07/11/2002	07/26/2002	7	7	8.89
02183N020451	06/27/2002	06/27/2002	07/12/2002	6	7	23.00		
02183N020450	06/27/2002	06/27/2002	07/12/2002	6	7	151.46		
02178N035388	06/20/2002	06/20/2002	07/05/2002	6	7	18.11		
021390557687010	06/20/2002	06/20/2002	07/12/2002	6	7	7.38		
02196T217169	06/20/2002	06/20/2002	07/26/2002	6	7	120.30		
Total								\$ 1,654.83

Amendment 1 (continued)

All of the provisions of the original Agreement not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective **November 1, 2002** or as of the date it is approved by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

BY: *C. Warren Neel*
C. Warren Neel
Commissioner

DATE: 11/04/02

VOLUNTEER STATE HEALTH PLAN, INC.

BY: *Mark E. Austin*
Mark E. Austin
President and CEO

DATE: 10/31/02

APPROVED BY:

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

BY: *C. Warren Neel*
C. Warren Neel
Commissioner

DATE: 12-10-02

APPROVED BY:

**STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY**

BY: *John G. Morgan*
John G. Morgan
Comptroller

DATE: 12/18/02

CONTRACT SUMMARY SHEET

Contract Number	FA-02-14632-00	State Agency	Tennessee Department of Finance and Administration
		Division	Bureau of TennCare

Contractor	Vendor ID Number
VSHP (TennCare Select)	<input type="checkbox"/> V- <input type="checkbox"/> C-

Service Description
 Managed Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medicaid Population

Contract Begin Date	Contract End Date
07/01/01	12/31/02

Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66	839	134	11	<input type="checkbox"/> on STARS		

FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)
2002	6,755,937.23	11,843,931.25			18,599,868.48
2003	3,512,397.48	6,157,634.82			9,670,032.30
Total	10,268,334.71	18,001,566.07			28,269,900.78

<input type="checkbox"/>	Fiscal Year Funding is Strictly Limited	CFDA Number	93.778
<input type="checkbox"/>	Contractor is on STARS	State Fiscal Contact	
<input type="checkbox"/>	Current Form W-9 On File With Accounts OR Form W-9 Attached	Name Address Phone	Keith Gaither 729 Church Street, Nashville TN 37247-6501 (615) 532-1362
<input type="checkbox"/>	Service Provider Registered with F&A	Procuring Agency Budget Officer Approval Signature	
<input type="checkbox"/>	Contractor is a SUBRECIPIENT (as defined by OMB Circular A-133)	<i>Keith Gaither / RD 6/29/01</i> Keith Gaither	

COMPLETE FOR ALL AMENDMENTS (only)		
	Base Contract & Prior Amendments	This Amendment ONLY
Contract End Date		
Total		

Funding Certification

Pursuant to T.C.A., Section 9-6-113, I, John D. Ferguson, Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.

OCR Use Only

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 JUN 29 2001
 MANAGEMENT SERVICES

**AN AGREEMENT
FOR THE ADMINISTRATION OF
TENNCARE SELECT**

BETWEEN

**THE STATE OF TENNESSEE,
d.b.a TENNCARE**

AND

VOLUNTEER STATE HEALTH PLAN, INC.

CONTRACT NUMBER:

July 1, 2001

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**AGREEMENT
BETWEEN
THE STATE OF TENNESSEE, d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.**

This Professional Services Agreement, hereinafter referred to as the "TennCare Select Agreement" is entered into by and between THE STATE OF TENNESSEE, hereinafter referred to as "TENNCARE" and Volunteer State Health Plan, Inc., herein after referred to as "the CONTRACTOR" for the administration of the state's TennCare health plan, "TennCare Select".

WHEREAS, the purpose of this Agreement is to: (1) provide services to populations who are more difficult to serve because of their health care needs, their mobility, and/or their geographic location; and (2) to serve as a back-up in any area of the state where TennCare enrollees cannot be adequately served by other TennCare HMOs, either in the event of the unexpected exit of an existing risk HMO or a need for additional capacity;

WHEREAS, consistent with HCFA policy the State desires to examine and evaluate a service delivery strategy that will conform to new federal criteria regarding children with special health care needs;

WHEREAS, the State is committed to the implementation of the Remedial Plan for Children in State Custody as filed with the court on May 12, 2000; however, consistent with the Revised Remedial Plan submitted to Federal court on December 18, 2000 (John B. et al v. N. Menke et al, No. 3-98-0168) and subject to final approval, the state believes that a non-risk HMO can better serve children in state custody;

WHEREAS, the CONTRACTOR has successfully demonstrated an ability to provide TennCare services under the Contractor Risk Agreement dated September 11, 1995 as amended and has provided said services for a period of approximately seven years;

WHEREAS, the CONTRACTOR, as a major health maintenance organization in the State of Tennessee, has an established state-wide provider network that can be amended, at the provider's option, to provide the health care services described in this Agreement;

WHEREAS, the CONTRACTOR has a demonstrated record of timely claims processing;

WHEREAS, the CONTRACTOR is a corporation which has qualified as a Health Maintenance Organization as described in the Code of Federal Regulations 42 CFR Part 434 or complies with Tennessee Code Annotated Section 56-32-201 (et. Seq.), is licensed to operate as a health maintenance organization in the State of Tennessee, is capable of arranging for health care services provided to covered persons for whom it has received an administrative payment and is engaged in said business and is willing to do so upon and subject to the terms and conditions hereof;

NOW, THEREFORE, in consideration of the mutual promises contained herein the parties have agreed and do hereby enter into this Agreement according to the provisions set forth herein:

1 GENERAL PROVISIONS

1-1 Notice and Agreement

All notices required to be given under this Agreement shall be given in writing, and shall be sent by United States Certified Mail, Postage Prepaid, Return Receipt Requested, to the appropriate party at the address given below, or at such other address (or addresses) as may be provided by notice given under this Section.

If to TENNCARE:

Mark E. Reynolds,
Deputy Commissioner
Bureau of TennCare
729 Church Street
Nashville, Tennessee 37247-6501

If to the CONTRACTOR:

Vicky Gregg
President and CEO
801 Pine Street
Chattanooga, Tennessee 37402-2555

1-2 Entire Agreement

This Agreement, including any Amendments or Attachments, represents the entire agreement between the CONTRACTOR and TENNCARE with respect to TennCare Select, the state's self-insured TennCare health plan. Correspondence and memorandums of understanding do not constitute part of this Agreement.

In the event of a conflict of language between the Agreement and any Amendments, the provisions of the Amendments shall govern. All applicable laws, regulations, court orders and policies (hereinafter referred to as Applicable Requirements), including those described in Section 6 of this Agreement are incorporated by reference into this Agreement. Any changes in those Applicable requirements shall be automatically incorporated into this Agreement by reference as soon as they become effective, provided, however, that nothing contained herein shall prejudice, restrict or otherwise limit the CONTRACTOR's right to maintain existing actions or initiate future actions challenging such Applicable Requirements in a court of competent jurisdiction, including seeking to stay or enjoin the applicability or incorporation of such requirements into this Agreement.

1-3 Definitions

The terms used in this Agreement shall be given the meaning used in the Rules and Regulations of the Bureau of TennCare. However, the following terms when used in this Agreement, shall be construed and/or interpreted as follows, unless the context expressly requires a different construction and/or interpretation. In the event of a conflict in language between the Definitions, Addendum, Attachments, and other Sections of this Agreement, the language in Sections 1 through 7 of this Agreement shall govern.

1. Administrative Cost - All costs to the Contractor related to the administration of this Agreement. Costs of subcontractors engaged solely to perform a non-medical administrative function for the CONTRACTOR specifically related to securing or fulfilling the CONTRACTOR's obligations to TENNCARE under the terms of this Agreement (e.g., claims processing, marketing) are considered to be an "administrative cost".

2. Adverse Action - Any action taken by the Contractor to deny, reduce, terminate, delay or suspend a covered service as well as any other acts or omissions of the Contractor which impair the quality, timeliness or availability of such benefits.
3. Appeal Procedure - The process to resolve an enrollee's right to contest verbally or in writing, any adverse action taken by the CONTRACTOR to deny, reduce, terminate, delay, or suspend a covered service as well as any other acts or omissions of the CONTRACTOR which impair the quality, timeliness or availability of such benefits. The appeal procedure shall be governed by TennCare rule 1200-13-12-.11 and any and all applicable court orders. Complaint shall mean an enrollee's right to contest any other action taken by the CONTRACTOR or service provider other than those that meet the definition of an adverse action.
4. Benefits - A schedule of health care services to be delivered to enrollees covered in the CONTRACTOR's plan developed pursuant to Section 2 of this Agreement.
5. Best Practice Guidelines - Guidelines for provision of health and behavioral health services to children in state custody.
6. Best Practice Network (BPN) - A group of Best Practice Providers.
7. Best Practice Provider (BPP) - A provider (primary care, behavioral health, or dental) who has been determined by the state to have the interest, commitment, and competence to provide appropriate care for children in state custody, in accordance with the Remedial Plan and statewide Best Practice Guidelines, and who has agreed to be in the MCO network.
8. Behavioral Health Organization (BHO) - An entity which organizes and assures the delivery of mental health and substance abuse services.
9. Behavioral Health Referral Center - Either a tertiary pediatric center, private psychiatric group, or other entity which contracts with the state to develop the behavioral health capacity needed to serve as the safety-net to provide assessments and care plans for children in custody.
10. Case Manager - An organization or a provider responsible for supervising or coordinating the provision of initial and primary care to patients; for initiating and/or authorizing referrals for specialty care; and for monitoring the continuity of patient care services.
11. Carve-out for Children in State Custody - An arrangement that TennCare establishes so that all children in state custody are assigned to one MCO and one BHO.
12. Center of Excellence for Children in or at Risk of State Custody - Tertiary care academic medicine center designated by the state as possessing, or being in a position to quickly develop, expertise in pediatrics, child behavioral health issues (including aggression, depression, attachment disorders and sexualized behaviors), and the unique health care needs of children in or at risk of state custody.
13. Center of Excellence for AIDS - Integrated networks designated by the State as able to provide a standardized and coordinated delivery system encompassing a range of services needed by TennCare eligibles with HIV disease.
14. CFR - Code of Federal Regulations.
15. Children At Risk of State Custody - Children who are determined to belong in one of the following two groups:
 - a. Children at imminent risk of entering custody - Children who are at risk of entering state custody as identified pursuant to TCA 37-5-103(10).
 - b. Children at serious risk of entering custody - Children whom DCS has identified as a result of a CPS referral; or children whose parents or guardians are considering voluntary surrender (who come to the

attention of DCS); and who are highly likely to come into custody as a result of being unable to access behavioral health services.

16. Children with Special Health Needs Steering Panel (CSHN Steering Panel) - An entity comprised of representatives of providers, advocates, the State, the plaintiffs of the Revised Remedial Plan, managed care entities, and referral sites whose responsibility will be to guide and assess the development of a health service system for children in state custody, and where appropriate, make recommendations to the Executive Oversight Committee.
17. Clarification - A revision that is not a change or amendment to the Agreement but is only a revision in language to more accurately reflect the existing agreement between the parties. Such clarification is a housekeeping item only, and as such, bears an effective date of the Agreement.
18. Clean claim - A claim received by the MCO for adjudication, and which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by the MCO.
19. Community Service Area - Community Service Area (CSA) shall mean one (1) or more counties in a defined geographical area in which the CONTRACTOR is authorized to enroll and serve TennCare members in exchange for a monthly fee.

The following geographical areas shall constitute the twelve (12) Community Service Areas in Tennessee:

Northwest CSA	-	Lake, Obion, Weakley, Henry, Dyer, Crockett, Gibson, Carroll and Benton
Southwest CSA	-	Lauderdale, Haywood, Madison, Henderson, Decatur, Tipton, Fayette, Hardeman, Hardin, Chester and McNairy
Shelby CSA	-	Shelby County
Mid-Cumberland CSA	-	Stewart, Montgomery, Robertson, Sumner, Trousdale, Houston, Dickson, Cheatham, Wilson, Humphreys, Williamson and Rutherford
Davidson CSA	-	Davidson County
South Central CSA	-	Perry, Hickman, Maury, Marshall, Bedford, Coffee, Wayne, Lewis, Lawrence, Giles, Lincoln and Moore
Upper Cumberland CSA	-	Macon, Clay, Pickett, Smith, Jackson, Overton, Fentress, Dekalb, Putnam, Cumberland, White, Cannon, Warren and Van Buren
Southeast CSA	-	Franklin, Grundy, Sequatchie, Bledsoe, Rhea, Meigs, McMinn, Polk, Bradley and Marion
Hamilton CSA	-	Hamilton County
East Tennessee CSA	-	Scott, Campbell, Claiborne, Morgan, Anderson, Union, Grainger, Hamblen, Jefferson, Cocke, Sevier, Blount, Monroe, Loudon and Roane
Knox CSA	-	Knox County
First Tennessee CSA	-	Hancock, Hawkins, Sullivan, Greene, Washington, Unicoi, Carter and Johnson

20. Complaint - The process to resolve an enrollee's right to contest any action taken by the CONTRACTOR or service provider other than an adverse action. The CONTRACTOR shall not treat anything as a complaint that falls within the definition of adverse action.
21. Covered Service - See Benefits.
22. Credentialing Verification Organization - The organization contracting with the State to verify primary care provider and all other physician credentials.
23. Department of Children's Services (DCS) - The state agency responsible for child protective services, foster care, adoption, programs for delinquent youth, probation, aftercare, treatment and rehabilitation programs for identified youth, and licensing for all child-welfare agencies, except for child (day) care agencies and child support.
24. DCS Custody Children - Children who have been identified by DCS as belonging in one of the following groups:
 - a. Children in the custody of DCS—Children in the legal and physical custody of DCS whose living arrangement is provided by DCS.
 - b. Children in the legal, but not physical, custody of DCS—Children who are in DCS's legal custody but who reside with parents or guardians or other caretakers.
25. DHHS - United States Department of Health and Human Services.
26. Disenrollment - The discontinuance of a member's entitlement to receive covered services under the terms of this Agreement, and deletion from the approved list of members furnished by TENNCARE to the CONTRACTOR.
27. Eligible Person - Any person certified by TENNCARE as eligible to receive services and benefits under the TennCare Program.
28. Emergency Medical Services (or Emergency Services) - Covered inpatient and outpatient services furnished by a qualified provider that are needed to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard; and emergency ambulance transport.
29. Emergency Medical Condition - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
30. Enrollee - Any person who has enrolled in the CONTRACTOR's plan in accordance with the provisions of this Agreement. (See Member, also).
31. Enrollee Month - A month of health care coverage for a TennCare eligible enrolled in an MCO plan.
32. Enrollment - The process by which a person becomes a member of the CONTRACTOR's plan through the TennCare Bureau.
33. Essential Hospital Services - Hospital services to which it is essential for an MCO to provide access. Essential Hospital services include neonatal, perinatal, pediatric, trauma and burn services.
34. Executive Oversight Committee - The Committee with primary oversight responsibility for the implementation of the revised remedial plan.

- 35. Facility – Any premises (a) owned, leased, used or operated directly or indirectly by or for the CONTRACTOR or its affiliates for purposes related to this Agreement; or (b) maintained by a subcontractor or provider to provide services on behalf of the CONTRACTOR.
- 36. Fee-for-Service - A method of making payment for health services based on a fee schedule that specifies payment for defined services.
- 37. FTE - Full time equivalent position.
- 38. Grand Region – A defined geographical region that includes specified Community Service Areas in which a CONTRACTOR is authorized to enroll and serve TennCare members in exchange for a monthly fee. The following Community Service Areas constitute the three (3) Grand Regions in Tennessee:

<u>East Grand Region</u>	<u>Middle Grand Region</u>	<u>West Grand Region</u>
First Tennessee	Upper Cumberland	Northwest
East Tennessee	Mid Cumberland	Southwest
Knox	Davidson	Shelby
Southeast Tennessee	South Central	
Hamilton		

- 39. HCFA - Health Care Financing Administration.
- 40. Health Maintenance Organization (HMO) - An entity certified by the Department of Commerce and Insurance under applicable provisions of Tennessee Code Annotated (T.C.A.) Title 56, Chapter 32.
- 41. Health Services Team/Implementation Team - A team consisting of an administrator /case manager, pediatrician, mental health professional and clerical support who are charged with staffing the Executive Oversight Committee and the steering panel overseeing the operational details of the Revised Remedial Plan. The Implementation Team can determine if services which have been ordered for children in custody or at imminent risk of custody and denied by the MCO are to be implemented while awaiting the results of an appeal.
- 42. Hospice - Services as described in Medicaid rule 1200-13-10 and the Code of Federal Regulations 42 CFR Part 418 which are provided to terminally ill individuals who elect to receive hospice services provided by a certified hospice agency.
- 43. IRS - Drugs that are Identical, Related or Similar to LTE drugs.
- 44. LTE - Drugs that the Food and Drug Administration (FDA) considers to be Less Than Effective because there is a lack of substantial evidence of effectiveness for all labeled indications and for which there is no compelling justification for their medical need.
- 45. MCO and BHO Coordination Agreement – An agreement between the MCO and BHO that specifies roles and responsibilities of each organization designed to assure care coordination, case management and continuity of care.
- 46. Managed Care Organization (“MCO”) - An HMO which participates in the TennCare program.
- 47. Marketing - Any activity conducted by or on behalf of the CONTRACTOR where information regarding the services offered by the CONTRACTOR is disseminated in order to persuade eligible persons to enroll or accept an application for enrollment in the CONTRACTOR's plan operated pursuant to this Agreement.
- 48. Market Area - One (1) or more community service areas in which the CONTRACTOR is authorized, by terms of this Agreement, to market eligible persons for enrollment in the CONTRACTOR's plan.

49. Medical Record - A single complete record kept at the site of the member's treatment(s), which documents all of the treatment plans developed, medical services ordered for the member and medical services received by the member.
50. Medically Necessary - Services or supplies provided by an institution, physician, or other provider that are required to identify or treat a TennCare enrollee's illness, disease, or injury and which are:
- a. Consistent with the symptoms or diagnosis and treatment of the enrollee's illness, disease, ailment, or injury; and
 - b. Appropriate with regard to standards of good medical practice; and
 - c. Not solely for the convenience of an enrollee, physician, institution or other provider; and
 - d. The most appropriate supply or level of services which can safely be provided to the enrollee. When applied to the care of an inpatient, it further means that services for the enrollee's medical symptoms or condition require that the services cannot be safely provided to the enrollee as an outpatient; and
 - e. When applied to enrollees under 21 years of age, services shall be provided in accordance with EPSDT requirements including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.
51. Member - A person who enrolls in the CONTRACTOR's plan under the provisions of this Agreement with TENNCARE. (See Enrollee, also).
52. NAIC -- National Associations of Insurance Commissioners.
53. Non-Contract Provider - Any person, organization, agency, or entity that is not directly or indirectly employed by or through the CONTRACTOR or any of its subcontractors pursuant to the Agreement between the CONTRACTOR and TENNCARE.
54. Out-of-Plan Services - Services provided by a non-contract provider.
55. Pharmacy Benefits Manager (PBM) -- An entity responsible for the provision and administration of pharmacy services.
56. Post-stabilization Care Services - Non-emergency services subsequent to an emergency that a treating physician views as medically necessary after an emergency medical condition has been stabilized.
57. Presumptive Eligible - Temporary eligibility granted to a pregnant woman whose family income is at or below a specified percentage of the federal poverty level in order for the woman to receive prenatal care services.
58. Primary Care Physician - A physician responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care. A primary care physician is a physician who has limited his practice of medicine to general practice or who is a Board Certified or Eligible Internist, Pediatrician, Obstetrician/Gynecologist, or Family Practitioner.
59. Primary Care Provider - A primary care physician or registered professional nurse or physician assistant practicing in accordance with state law who is responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care.
60. Primary Treatment Center (PTC) - A center developed by DCS for the purpose of providing short-term evaluation and treatment to children who have just come into custody, children already in state custody, children who have been released from state custody and who have been recommitted, and children who are at imminent risk of entering custody.

61. Prior Authorization - The act of authorizing specific services or activities before they are rendered or activities before they occur.
62. Program Integrity - The Program Integrity unit is responsible for assisting with the prevention, identification and investigation of fraud and abuse within the health care system.
63. Provider - An institution, facility, agency, person, corporation, partnership, or association approved by TENNCARE which accepts as payment in full for providing benefits the amounts paid pursuant to a provider agreement with the CONTRACTOR.
64. Provider Agreement - An agreement between an MCO and a provider or an MCO's subcontractor and a provider of health care services which describes the conditions under which the provider agrees to furnish covered services to the MCO's members.
65. Quality Improvement (QI) - The ongoing process of responding to data gathered through quality monitoring efforts, in such a way as to improve the quality of health care delivered to individuals. This process necessarily involves follow-up studies of the measures taken to effect change in order to demonstrate that the desired change has occurred.
66. Quality Monitoring (QM) - The ongoing process of assuring that the delivery of health care is appropriate, timely, accessible, available, and medically necessary and in keeping with established guidelines and standards and reflective of the current state of medical knowledge.
67. "Revised Remedial Plan" (for Children in State Custody) - The plan submitted to Federal court on December 18, 2000 that contains revisions to the Remedial Plan to insure the proper coordination and delivery of health services for children in custody through a carve-out entity.
68. "Remedial Plan" (for Children in State Custody) - The Agreed Order entered into by the state to insure the proper coordination and delivery of health services for children in custody, pursuant to the EPSDT mandate of the Medicaid Act and in accordance with the EPSDT Consent Decree.
69. Savings - Residual monies remaining after the administrative costs described in this Agreement are deducted from administrative payment fees paid by TENNCARE.
70. Service Location - Any location at which an enrollee obtains any health care service covered by the CONTRACTOR pursuant to the terms of this Agreement.
71. Service Site - The locations designated by the CONTRACTOR at which members shall receive primary care provider and preventive services.
72. Services - The benefits described in Section 2-3 and the Quality of Care Monitors (Attachment II of this Agreement).
73. Shall - Indicates a mandatory requirement or a condition to be met.
74. Specialty Services - Includes Essential Hospital Services, services provided by Centers of Excellence, and specialty physician services.
75. State - State of Tennessee.
76. Subcontract - An agreement entered into by the CONTRACTOR with any other organization or person who agrees to perform any administrative function or service for the CONTRACTOR specifically related to securing or fulfilling the CONTRACTOR's obligations to TENNCARE under the terms of this Agreement, (e.g., claims processing, marketing) when the intent of such an agreement is to delegate the responsibility for any major service or group of services required by the TENNCARE/MCO Agreement. This shall also include any and all agreements between any and all subcontractors for the purposes related to securing or fulfilling the CONTRACTOR's obligations to TENNCARE under the terms of this

Agreement. Agreements to provide covered services as described in Section 2-3 of the TENNCARE/MCO Agreement shall be considered Provider Agreements and governed by Section 2-18 of this Agreement.

77. Subcontractor - Any organization or person who provides any function or service for the CONTRACTOR specifically related to securing or fulfilling the CONTRACTOR's obligations to TENNCARE under the terms of this Agreement.
78. TennCare - The State of Tennessee and any entity authorized by statute or otherwise to act on behalf of the State of Tennessee in administering and/or enforcing the terms of this Agreement. Such entity(s) may include, but are not limited to, the TennCare Bureau, the Department of Health, the Department of Finance and Administration, the Department of Mental Health and Mental Retardation, the TennCare Division within the Tennessee Department of Commerce and Insurance and the Tennessee Bureau of Investigation, Medicaid Fraud Control Unit.
79. Tennessee Bureau of Investigation, Medicaid Fraud Control Unit (TBI MFCU) -- The State agency responsible for the investigation of provider fraud and abuse in the State Medicaid Program.
80. Tennessee Department of Mental Health and Developmental Disabilities ("TDMHDD") - The State agency having the statutory authority to provide care for persons with mental illness and persons with developmental disabilities. For the purposes of this Agreement, TDMHDD shall mean the State Of Tennessee and any entity authorized by statute or otherwise to act on behalf of the State of Tennessee in administering and/or enforcing the terms of this Agreement.
81. Tertiary Pediatric Center (Center of Excellence for Children in or at risk of Custody) - A site recognized by the services it offers to be a referral site for children needing the highest level of physical care. The five recognized tertiary care centers for pediatrics are in Johnson City, Knoxville, Chattanooga, Nashville, and Memphis.
82. Third Party Resource - Any entity or funding source other than the enrollee or his/her responsible party, which is or may be liable to pay for all or part of the cost of medical care of the enrollee.
83. Third Party Liability -- Any amount due for all or part of the cost of medical care from a third party.
84. Vital MCO Documents -- Consent forms and notices pertaining to the reduction, denial, delay, suspension or termination of services.

1-4 Applicability of this Agreement

All terms, conditions, and policies stated herein apply to staff, agents, officers, subcontractors, providers, volunteers and anyone else acting for or on behalf of the CONTRACTOR. TennCare enrollees are the intended third party beneficiaries of contracts between the state and managed care organizations and of any subcontracts or provider agreements entered into by managed care organizations with subcontracting providers and, as such, enrollees are entitled to the remedies accorded to third party beneficiaries under the law. This provision is not intended to provide a cause of action against the Bureau of TENNCARE or the State of Tennessee by enrollees beyond any that may exist under state or federal law.

2 CONTRACTOR RESPONSIBILITIES

2-1 General

The CONTRACTOR shall comply with all the provisions of this Agreement and amendments and shall act in good faith in the performance of the provisions of said Agreement. The CONTRACTOR shall respect the individual legal rights (including rights conferred by the Agreement) of every enrollee, regardless of the individual's family status as head of household, dependent, or otherwise. Nothing in this Agreement shall be construed to limit the rights or remedies of enrollees under state or federal law. The CONTRACTOR acknowledges that failure to comply with aforementioned provisions may result in the assessment of liquidated damages and/or termination of the Agreement in whole or in part, and/or imposition of other sanctions as set forth in Section 6 of this Agreement.

The CONTRACTOR shall comply with the following requirements at the inception of this Agreement and at all times during the life of this Agreement:

- a. Be appropriately licensed to operate within the State of Tennessee.
- b. Demonstrate the existence of a network of health care providers capable of providing comprehensive health care services as defined in this Agreement and in accordance with TennCare Program criteria for time/distance/location/patient volume, to all enrollees in the CONTRACTOR's plan.

Services shall, to the extent practical considering quality, accessibility and cost, be provided within the community service area(s) served by the MCO, unless otherwise authorized by TENNCARE.
- c. Demonstrate sufficient capacity to provide services in accordance with the requirements of this Agreement for up to 300,000 enrollees or the actual number of enrollees enrolled, whichever is greater. This provision is not intended to guarantee enrollment of 300,000 enrollees, nor limit enrollment to 300,000 enrollees. Rather, it is intended to demonstrate the CONTRACTOR's ability and readiness to serve as back-up health plan in the event of a failure of a risk MCO.
- d. Clearly demonstrate the capability and intent to provide primary care case management services to TennCare eligible enrollees either by the organizational structure of the MCO using case managers or by primary care providers (PCPs), at the MCO's discretion, for all health care services provided to enrollees.
- e. Assure availability of service providers outside the community service network for covered services that are not commonly provided in that particular community area.
- f. In accordance with Title 56, Chapter 32, Part 2, or the CONTRACTOR's Certificate of Authority requirements, whichever is greater, demonstrate sufficient financial capital to ensure uninterrupted delivery of health care on an ongoing basis.
- g. Demonstrate sufficient network capability and a willingness, when so directed by TENNCARE, to accept a reasonable number of enrollees enrolled, or requesting enrollment, in any health plan operating in the same community as the CONTRACTOR, including any plan which fails, is terminated in whole or in part, becomes unable to take new enrollees, maintain existing enrollment or discontinues service in the area for any reason. Notwithstanding any provision herein to the contrary, the State reserves the right to transfer enrollee members based upon the demonstrated capacity of the CONTRACTOR, when the State determines that it is in the best interests of the TENNCARE program.
- h. Comply with clear and measurable Provider Network, Claims Processing, Financial/Actuarial, Clinical/Quality and Member/Provider service standards of accountability defined by TENNCARE and specified in this Agreement. Specific workgroups with MCO representation will be assigned to develop benchmarks for Clinical/Quality performance indicators specified in Attachment II.

- i. The CONTRACTOR shall provide the capability of electronic billing for all of their TennCare plans offered in Tennessee. The CONTRACTOR or any entities acting on behalf of the CONTRACTOR shall not charge providers for filing claims electronically. However, this provision shall not be construed to imply that providers may not be responsible for payment of applicable line fees and/or charges. The CONTRACTOR shall comply at all times with standardized paper billing forms/format as follows:

<u>Claim Type</u>	<u>Claim Form</u>
Professional	HCFA 1500
Institutional	UB-92
Pharmacy	NCPDP (Edit Format)
Dental	ADA

The CONTRACTOR shall not revise or modify the standardized form or format itself. Further, the CONTRACTOR agrees to adopt national EMC standards and standardized instructions and definitions that are consistent with industry norms for the forms identified above when developed by TENNCARE in conjunction with appropriate workgroups.

As required in Sections 2.9.7 and 6 of this Agreement, the CONTRACTOR also agrees to comply with the Health Insurance Portability and Accountability Act (HIPAA). Further, the CONTRACTOR agrees that at such time that TENNCARE in conjunction with appropriate work groups presents recommendations concerning claims billing and processing that are consistent with industry norms, the CONTRACTOR shall comply with said recommendations within one hundred and eighty (180) days from notice by TENNCARE to do so.

The CONTRACTOR agrees to comply with prompt pay claims processing requirements in accordance with TCA 56-32-226.

Failure to comply with the aforementioned claims processing requirements shall result in the CONTRACTOR being required to implement a corrective action plan as described in Section 2-16, and shall result in the application of liquidated damages and/or intermediate sanctions as described in Section 6-8 of this Agreement.

- j. Agree to adhere to the quality standards and preventive health standards that are required by TENNCARE.
- k. Unanimously agree with other MCOs in the TennCare system for the provision of pharmacy services to TennCare enrollees who reside in long term care facilities (nursing homes) so that only one pharmacy (unit dose vendor) shall be responsible for the provision of pharmacy services to all TennCare enrollees in each nursing home. The scope of pharmacy services available to long term care facility residents shall be the scope of pharmacy services available under the MCO plan to enrollees not residing in the long term care facility. The MCOs will agree on the pharmacy providing the services and the formulary used in each facility; however, the rates of reimbursement, claims submission methods and payment schedules for pharmacy services will be determined by each individual MCO plan.
- l. Agree to not require service providers to accept TennCare Select reimbursement amounts for services provided under any non- TennCare plan operated or administered by the CONTRACTOR.
- m. Agree to report all provider related data required pursuant to this Agreement to TENNCARE using a uniform provider number (i.e., All MCOs must transmit each provider related record to TENNCARE using the same provider identification number regardless of which or how many MCOs the provider participates in.) The uniform number to be reported for all providers except pharmacy will be the traditional "Medicaid" provider number. Prior to payment of a claim, the MCO shall require that providers that have not been enrolled in the TennCare Program previously as a Medicaid provider or as a provider who currently receives direct payment from TENNCARE (i.e., Medicare cost sharing) contact the Medicaid/TennCare Provider Enrollment Unit and obtain a "Medicaid" provider number. The issuance of a provider number by TennCare is simply for the purpose of establishing a common provider number for reporting purposes as required by this Section and does not imply any enrollment in the TennCare program or that TENNCARE has credentialed the provider or convey any other contractual relationship or any other responsibility with the provider. Pharmacy providers shall use the National Association Board of

Pharmacy (NABP) number that has been assigned. At such time as TENNCARE makes a Medicaid Provider I.D. listing available to pharmacists, the CONTRACTOR shall capture and report the prescribing provider's Medicaid provider number as required in Attachment XII, Exhibit G of this Agreement. CONTRACTOR agrees that at such time that the Health Care Financing Administration establishes a national uniform identification number, at the State's request, the CONTRACTOR shall agree to utilize HCFA's newly established uniform provider numbers for all provider reporting purposes.

- n. Agree to display notices of the enrollee's right to appeal adverse actions affecting services in public areas of the CONTRACTOR's facility(s) in accordance with TennCare rules, regulations, policies and court orders.
- o. The CONTRACTOR shall assure that one month prior to and throughout the annual MCO choice period, all communication and/or materials representing the CONTRACTOR's provider network shall accurately reflect the CONTRACTOR's provider network that will be available to enrollees on the enrollees' effective date. The CONTRACTOR shall not take action to disenroll an in-network primary care provider, specialist, or hospital provider to be included in the MCOs network for the upcoming calendar year after the first of September for one year except for the following:
 - 1. The provider has repeatedly failed to comply with the CONTRACTOR's policies and or procedures, the CONTRACTOR has received repeated and/or numerous enrollee complaints regarding the provider, there is reasonable suspicion that the provider is impaired due to drug or alcohol abuse or existing medical conditions, etc.; or
 - 2. The provider and the CONTRACTOR are unable to negotiate continuance of the provider agreement; or
 - 3. Provider requests disenrollment; or
 - 4. The provider has been excluded from participation in the Medicare and/or Medicaid programs pursuant to Sections 1128 or 1156 of the Social Security Act; or
 - 5. The provider has lost his/her license or is otherwise not in good standing with the TENNCARE program;
 - 6. The provider fails credentialing or re-credentialing; or
 - 7. Any other reason approved in writing by TENNCARE.
- p. The CONTRACTOR shall utilize the Credentialing Verification Organization (CVO) contracted by the State to verify primary care provider and all other physician credentials as described in Section 2-9.6 of this Agreement.
- q. Agree to coordinate reimbursement to enrollees identified by TennCare who have incurred cost-sharing liabilities in excess of their out of pocket expenditure maximum.
- r. Mutually agree to such other requirements as may be reasonably established by TENNCARE.
- s. Agree to educate primary care providers and encourage them to submit the appropriate diagnosis codes identified by TennCare in conjunction with evaluation and management procedure codes for EPSDT services and monitor compliance.

2-2 Remedial Plan Requirements

- a. The CONTRACTOR shall develop and maintain a Best Practice Network of providers with the appropriate expertise and experience and willingness in the special health care needs of children in state custody.
- b. The CONTRACTOR hereby agrees to serve as the designated carve-out MCO for the purpose of meeting the requirements of the Revised Remedial Plan and agrees to satisfy all special requirements for the delivery of services to children in state custody. If the Revised Remedial Plan is not approved by the court, the CONTRACTOR agrees to participate fully in the implementation of the Remedial Plan for Children as filed with the Federal Court on May 12, 2000.

2-3 TennCare Covered Benefits and Service Limitations

2-3.1 Covered Benefits

The CONTRACTOR shall cover, at a minimum, the services and benefits as outlined below.

SERVICE	BENEFIT
Inpatient Hospital Days (including days at a designated perinatal center)	As medically necessary. Pre-admission approval and concurrent reviews allowed.
Outpatient Hospital Services	As medically necessary.
Physician Inpatient Services	As medically necessary. This shall include acupuncture performed by a Physician or a registered nurse as an anesthetic in connection with a surgical procedure.
Physician Outpatient Services	As medically necessary. This shall include acupuncture performed by a Physician or a registered nurse as an anesthetic in connection with a surgical procedure.
Lab & X-Ray Services	As medically necessary.
Newborn Services	As medically necessary including circumcisions performed by a physician.
Hospice Care (must be provided by an organization certified pursuant to Medicare Hospice requirements)	As medically necessary.
Dental Services	Preventive, diagnostic and treatment services for enrollees under age 21. Services for enrollees age 21 or older limited to cases of accidental injury to or neoplasms of the oral cavity, life threatening infection, accidental injury to natural teeth including their replacement (limited to the cost of bridgework of the replacement of teeth injured in an accident unless teeth implants are medically necessary) and the removal of impacted wisdom teeth. (The adult dental "accident" must be caused by some external force, like a car accident, not by some normal act of mastication, or grinding of teeth while sleeping, or any other naturally occurring circumstance.) Orthodontics limited to individuals under 21 except when an orthodontic treatment plan is approved prior to the enrollee attaining 20 1/2 years of age, and treatment is initiated prior to the recipient attaining 21 years of age, or when orthodontic treatment is the result of facial hemiatrophy or congenital birth defects (if enrollee was covered by TennCare at birth).

Vision Services	Preventive, diagnostic and treatment services (including eyeglasses) for enrollees under age 21. The first pair of cataract glasses or contact lens/lenses following cataract surgery is covered for adults.
Home Health Care	As medically necessary.
Pharmacy Services (obtained directly from an ambulatory retail pharmacy setting, outpatient hospital pharmacy, mail order pharmacy or those administered to a long term care facility resident (nursing facility))	<p>As medically necessary. Non-covered therapeutic classes as described in 2-13.13, DESI, LTE, IRS drugs excluded.</p> <p>Effective July 1, 2000, TENNCARE shall assume responsibility for the provision and payment of pharmacy benefits to individuals who are enrolled in the TennCare Program in the category of TennCare/Medicare dual eligible. (However, this does not include pharmaceuticals administered in a doctor's office or through Home Health Services).</p> <p>TENNCARE is not responsible for the provision and payment of pharmacy services for TennCare/Medicare dual eligibles prior to the date that TENNCARE has notified the CONTRACTOR through the regular electronic eligibility update that these individuals are eligible in the TennCare/Medicare dual eligible category.</p>
Durable Medical Equipment	As medically necessary.
Medical Supplies	As medically necessary.
Emergency Ambulance Transportation	As medically necessary.
Non-Emergency Ambulance Transportation	As medically necessary.
Non-Emergency Transportation	<p>As necessary for enrollees lacking accessible transportation for covered services.</p> <p>The travel to access primary care and dental services must meet the requirements of the waiver terms and conditions. The availability of specialty services as related to travel distance should meet the usual and customary standards for the community. However, in the event the MCO is unable to negotiate such an arrangement for an enrollee, transportation must be provided regardless of whether or not the enrollee has access to transportation. If the enrollee is a child, transportation must be provided for the child and an accompanying adult. However, transportation for a child shall not be denied pursuant to any</p>

	policy which poses a blanket restriction due to enrollees age or lack of parental accompaniment.
Community Health Services	As medically necessary.
Renal Dialysis Services	As medically necessary.
EPSDT Services for enrollees under age 21 in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.	Screening, diagnostic and follow-up treatment services as medically necessary in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989 for enrollees under 21. Screens shall be in accordance with the periodicity schedule set forth in the latest "American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care" and all components of the screens must be consistent with the latest "American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care". Tools to be used for screenings shall be consistent with the EPSDT Screening Guidelines as described in Attachment VIII of the Agreement. EPSDT services also include maintenance services which are services which have been determined to be effective in preventing or mitigating the worsening of an individual's conditions or preventing the development of additional health problems.
Rehabilitation Services	As medically necessary when determined cost effective by the MCO. All medically necessary services shall be provided to enrollees under 21 years of age in accordance with EPSDT requirements including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.
Chiropractic Services	When determined cost effective by the MCO.
Private Duty Nursing	As medically necessary and when prescribed by an attending physician for treatment and services rendered by registered nurse (R.N.) or a licensed practical nurse (L.P.N.), who is not an immediate relative.
Speech Therapy	As medically necessary, by a Licensed Speech Therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic or personality disorder. All medically necessary services shall be provided to enrollees under 21 years of age in accordance with EPSDT requirements including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.

Sitter	As medically necessary, a sitter who is not a relative may be used where an enrollee is confined to a hospital as a bed patient and certification is made by a network physician that R.N. or L.P.N. is needed and neither is available.
Convalescent Care	Upon receipt of proof that a Covered Person has incurred Medically Necessary expenses related to convalescent care, the Plan shall pay for up to and including the one-hundredth (100 th) day of confinement during any calendar year for convalescent facility(ies) room, board and general nursing care, provided: (1) a Physician recommends confinement for convalescence; (2) the enrollee is under the continuous care of a Physician during the entire period of confinement; and (3) the confinement is required for other than custodial care.
Organ Transplants and Donor Organ Procurement	As medically necessary for a covered organ transplant.
Reconstructive Breast Surgery	In accordance with Tennessee Public Chapter 452 which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy as well as any surgical procedure on the non-diseased breast deemed necessary to establish symmetry between the two breasts in the manner chosen by the physician. Note: Applicable CPT procedure codes regarding the revision of undiseased breast following mastopexy or mastectomy for breast cancer, for the purpose of restoring symmetry, shall be the CPT procedures codes in the following range: 19316 – 19396.

It is the intent of TENNCARE to contract directly with a dental vendor and assume responsibility for the provision and payment of dental benefits effective January 1, 2002. However, the CONTRACTOR shall maintain an adequate network for the provision of dental benefits until such time that TENNCARE provides the CONTRACTOR with written notice that TENNCARE will assume said responsibilities. TENNCARE shall provide the CONTRACTOR with sixty (60) days prior written notice with the understanding that said notice will become effective only in the event that appropriate approvals are granted and there are no outstanding issues that would prevent the State from securing the appropriate contract for the dental vendor.

2-3.2 Medical Necessity

The determination of medical necessity shall be made on a case by case basis. The CONTRACTOR shall not employ, and shall not permit others acting on their behalf to employ utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each TennCare enrollee and his/her medical history. The CONTRACTOR shall have the ability to place tentative limits on a service; however, such limits shall be exceeded when medically necessary based on a patient's individual characteristics. Any procedures used to determine medical necessity shall be consistent with the following definition:

Services or supplies provided by an institution, physician, or other provider that are required to identify or treat a TennCare enrollee's illness, disease, or injury and which are:

- i. Consistent with the symptoms or diagnosis and treatment of the enrollee's illness, disease, or injury; and
- ii. Appropriate with regard to standards of good medical practice; and
- iii. Not solely for the convenience of an enrollee, physician, institution or other provider; and
- iv. The most appropriate supply or level of services which can safely be provided to the enrollee. When applied to the care of an inpatient, it further means that services for the enrollee's medical symptoms or condition require that the services cannot be safely provided to the enrollee as an outpatient; and
- v. When applied to enrollees under 21 years of age, services shall be provided in accordance with EPSDT requirements including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.

2-3.3 Preventive Services

The following preventive medical services (identified by applicable CPT procedure codes and ADA procedure codes) shall be covered subject to any limitations described herein, within the scope of standard medical practice, and shall be exempt from any cost sharing responsibilities as described in Section 2-4.10 of this Agreement. In the event that the CPT codes listed below should be revised, consolidated, separated into individual parts, or replaced in part or in whole by new CPT codes, the services represented by the CPT codes listed below shall remain covered services. Vision services, hearing services, dental services and laboratory services not specifically listed herein, which are required pursuant to the Medicaid Early Periodic Screening, Diagnosis and Treatment (EPSDT) program for persons under age 21, shall be provided in accordance with the latest "American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care" periodicity schedule for such services. It is the responsibility of the MCO to educate providers as to the importance and necessity of documenting all of the components of the screen, and of using the appropriate codes as directed by TENNCARE to the MCOs. It is also the responsibility of the MCO to communicate this data to TENNCARE as directed.

Office Visits	
NEW PATIENT	ESTABLISHED PATIENT
99381 – Initial evaluation	99391 – Periodic reevaluation
99382 – age 1 through 4 years	99392 – age 1 through 4 years
99383 – age 5 through 11 years	99393 – age 5 through 11 years
99384 – age 12 through 17 years	99394 – age 12 through 17 years
99385 – age 18 through 39 years	99395 – age 18 through 39 years
99386 – age 40 through 64 years	99396 – age 40 through 64 years
99387 – age 65 years and over	99397 – age 65 years and over

Counseling and Risk Factor Reduction Intervention	
INDIVIDUAL	GROUP
99401 – approximately 15 minutes	99411 – approximately 30 minutes
99402 – approximately 30 minutes	99412 – approximately 60 minutes
99403 – approximately 45 minutes	
99404 – approximately 60 minutes	

Family Planning Services - If not part of a Preventive Services office visit, should be billed using the Counseling and Risk reduction individual codes (99401-99404). Family planning supplies and prescription drugs are also exempt from cost sharing responsibilities.

Prenatal Care

59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
59410	Vaginal delivery only (with or without episiotomy and/or forceps)
59425	Antepartum care only, 4-6 visits
59426	Antepartum care only, 7 or more visits
59430	Postpartum care only (separate procedure)
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
59515	Cesarean delivery only including postpartum care
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy and/or forceps) and postpartum, after previous cesarean delivery
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery

Other Preventive Services

99420	Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal)
90700 – 90744	Immunizations
92551	Screening test, pure tone, air only (Audiologic function)
92552	Pure tone audiometry (threshold); air only

Laboratory: Any laboratory test or procedure listed in the preventive services periodicity schedule when the service CPT code is one of the above preventive medicine codes. This includes mammography screening (76092) as indicated in the periodicity schedule.

Specific tests/procedures to be performed as part of the various visit codes listed above are found in the Quality of Care Monitor guidelines incorporated as Attachment II to this Agreement.

Preventive Dental Services for Children Under 21 Years of Age

D1110	Prophylaxis (when billed for children over age 12 and under age 21)
D1120	Prophylaxis
D1203	Topical Application of Fluoride (Prophylaxis not included) - child
D1310	Nutritional Counseling for Control of Dental Disease
D1320	Tobacco Counseling for the Control and Prevention of Oral Disease
D1330	Oral Hygiene Instructions
D1351	Sealant per Tooth

2-3.4 Dental Services

It is the intent of TENNCARE to contract directly with a dental vendor and assume responsibility for the provision and payment of dental benefits effective January 1, 2002. However, the CONTRACTOR shall maintain an adequate network for the provision of dental benefits until such time that TENNCARE provides the CONTRACTOR with written notice that TENNCARE will assume said responsibilities. TENNCARE shall provide the CONTRACTOR with sixty (60) days prior written notice with the understanding that said notice will become effective only in the event that appropriate approvals are granted and there are no outstanding issues that would prevent the State from securing the appropriate contract for the dental vendor.

2-3.5 Mental Health and Substance Abuse Services

All mental health related services and substance abuse services provided to enrollees shall be the responsibility of Behavioral Health Organizations (BHOs) who have a contractual arrangement with the Tennessee Department of Mental Health and Developmental Disabilities or the State. These services include:

- Psychiatric Inpatient Facility Services;
- Physician Psychiatric Inpatient Services;
- Outpatient Mental Health Services;
- Inpatient and Outpatient Substance Abuse Treatment Services;
- Psychiatric Pharmacy Services and Pharmacy Related Lab Services;
- Transportation to Covered Mental Health Services;
- Mental Health Case Management;
- 24-Hour Residential Treatment;
- Housing/Residential Care;
- Specialized Outpatient and Symptom Management;
- Specialized Crisis Services;
- Psychiatric Rehabilitation Services; and
- Services provided by an MCO Primary Care Provider with a behavioral health diagnosis code (ICD-9 CM 290.xx – 319.xx)

The CONTRACTOR is responsible for the payments and provision of covered services that are not mental health or substance abuse services. This carve out of mental health and substance abuse services shall not relieve the CONTRACTOR from the responsibility to assist in the coordination of mental health and medical care of enrollees. The CONTRACTOR shall assure active coordination between primary health care and mental health/substance abuse care, including case management and continuity of care services. The CONTRACTOR shall cooperate with the State's efforts to facilitate delivery of mental health services to the TennCare population and shall execute an MCO/BHO Coordination Agreement with the BHO for purposes of interfacing with the BHOs and assuring coordination of care, case management and continuity of care with the BHOs for purposes of coordinating appropriate health care.

The MCO/BHO Coordination Agreement shall be revised on or before September 1, 2001 and shall specify that the BHO shall not require MCO primary care providers to obtain prior authorization for the first six (6) behavioral health visits for each enrollee and that the MCO shall direct its network primary care providers to submit all services with a primary behavioral health diagnosis (ICD-9 290.xx – 319.xx) to the BHO for payment. The revised MCO/BHO Coordination Agreement must be approved by TENNCARE prior to execution.

Coordination of physical health care and mental health care shall include:

- Means for referral which assures immediate access for emergency care and a provision of urgent and routine care according to TennCare guidelines;
- Means for the transfer of information (to include items before and after the visit);
- Maintenance of confidentiality;
- Cooperation with the BHOs regarding training activities provided by the BHOs; and
- Provision of an updated primary care provider listing to the BHO on a quarterly basis.

When disputes arise between the enrollee's MCO and his or her BHO regarding responsibility for a particular medically necessary covered service, the BHO and the MCO shall coordinate to insure that the service will be delivered to enrollees and the MCO and the BHO must split the cost of the service pending resolution of any dispute between the BHO and the MCO. The "cost" of the service shall be the greater of (1) the cost if the MCO were responsible for providing the service or (2) the cost if the BHO were responsible for providing the service. Services to the enrollee must not be delayed because there is a dispute between the MCO and BHO over who is responsible for delivering the service. The enrollee's MCO and his or her BHO are jointly responsible for the enrollee, and the State will hold the MCO and the BHO jointly accountable for the quality of care the enrollee receives. BHO and

MCO may establish dispute resolution procedures in their Coordination Agreement in lieu of compliance with above dispute language so long as the member is held harmless except for applicable cost sharing responsibilities and care is not delayed.

Unresolved disputes between MCOs and BHOs shall be referred to the State or its designee for a decision on responsibility after the service has been delivered. Resolution of the disputes shall be governed according to the provisions set forth in this Section.

Either the MCO or the BHO may submit to the State a Request for Resolution regarding any dispute regarding payment for services under this provision. The Request for Resolution shall contain a concise description of the facts regarding the dispute, the applicable contract provisions, and the position of the party making the request. A copy of the Request for Resolution shall also be delivered to the other party. The other party shall then submit a Response to the Request for Resolution within fifteen (15) calendar days of the date of the Request for Resolution. The Response shall contain the same information required of the Request for Resolution. Failure to timely file a Response or obtain an extension from the State shall be deemed a waiver of any objections to the Request for Resolution. The State, or its designee, shall make a decision in writing regarding who is responsible for the payment of services as promptly as possible ("Decision"). Within five (5) working days of receipt of the Decision, the non-successful party shall reimburse any payments made by the successful party for the service together with interest on the payments at any lawful rate designated by the State. Interest shall begin to accrue from the date the service was delivered. In the event the CONTRACTOR is the non-successful party, the State shall be responsible for payment for the service together with interest on the payments. The non-successful party shall also pay to the State, within thirty (30) calendar days of the Decision, administrative costs for the dispute resolution as estimated by the State. The amount of the estimated cost shall be contained within the State's Decision. The obligations of the non-successful party to pay the amount specified in this provision are absolute and may not be withheld pending resolution of any court of competent jurisdiction. However, these payments may be made with reservation of rights regarding any such judicial resolution. If a party fails to pay the State for the administrative costs as described in this Section within thirty (30) calendar days, the State may deduct its amounts from any current or future amount owed the party.

Appeal of any Decision shall be to a court or commission of competent jurisdiction and shall not constitute a procedure under the Administrative Procedure Act, T.C.A. §4-5-201 et seq. Exhaustion of the above-described process shall be required before filing of any claim or lawsuit on issues covered by this Section.

2-3.6 Additional Services

The CONTRACTOR shall not advertise, offer or provide any services or incentives not required or permitted pursuant to this Agreement in addition to the required services that are covered within the scope of this Agreement except when such services, benefits or incentives have been specifically prior approved in writing by the State. Examples of services, benefits or incentives that may be approved by TENNCARE shall include, but are not limited to, educational programs intended to reduce the frequency or acuity of treatment for one or more specified medical conditions and any accompanying incentives given to enrollees to encourage participation in such educational programs.

2-3.7 Institutional Services and Alternatives to Institutional Services

Long term care institutional services in a nursing home, an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or waiver covered services provided through the Home and Community Based Services (HCBS) waiver for these institutional services are not covered by this Agreement and shall not be the responsibility of the CONTRACTOR to administer. These services shall be provided to qualified individuals as described in TennCare/Medicaid rules and regulations through contracts between TENNCARE and the appropriate facilities that provide these services. Convalescent care, as described in Section 2-3.1 of this Agreement, is considered to be short-term care and is not considered to be "long-term care institutional services" for purposes of this section.

Room and board expenses (including nursing care) in a nursing facility provided under the hospice benefit are not considered to be long-term care institutional services. Enrollees requiring long term care institutionalization or the HCBS waiver alternative shall be eligible for participation in the CONTRACTOR's plan for all MCO covered services and such services shall be the CONTRACTOR's responsibility to administer. Those TennCare covered

benefits which are not included in the Bureau of TennCare's per diem reimbursement for institutional services through the Long-Term Care Program shall be the responsibility of the CONTRACTOR (e.g., prosthetics, some items of durable medical equipment, non-emergency ambulance transportation, and non-emergency transportation). TennCare covered benefits that are not provided by TENNCARE through the aforementioned contracts shall be the responsibility of the CONTRACTOR to administer.

2-3.8 Coordination with Medicare

- a. The CONTRACTOR is responsible for coordinating TennCare-covered benefits with benefits offered by other insurance, including Medicare, which the enrollee may have. For Medicaid eligibles, such coordination must insure that TennCare-covered services are delivered without charge to the enrollee.
- b. TENNCARE is responsible for paying Medicare premiums, deductibles, and coinsurance for enrollees who are dually eligible for Medicaid and Medicare.
- c. TENNCARE is not responsible for paying Medicare premiums, deductibles, and coinsurance for enrollees who have Medicare but who are not also eligible for Medicaid. These costs are the responsibility of the enrollee. The CONTRACTOR may cover these costs as a cost-effective alternative service to take advantage of Medicare covered services, if said costs are lower than the cost of the service without Medicare coverage.

2-3.9 Use of Cost-Effective Alternative Services

The CONTRACTOR shall identify and recommend the use of cost-effective alternative services to the TennCare Medical Director. The TennCare Medical Director shall review and approve or disapprove the CONTRACTOR's recommendation. If services are determined to be medically appropriate and a cost-effective alternative, whether listed as covered or non-covered or omitted in this Agreement, the Contractor shall authorize the services.

2-3.10 Advance Directives

The CONTRACTOR shall comply with federal requirements concerning advance directives such as a living will or a durable power of attorney for healthcare, as described in 42 CFR 417.436 and 489 Subpart I, and as described in T.C.A. Section 32-11-105, Sections 34-6-201 through 34-6-215, and Sections 68-11-201 through 68-11-224, and as stipulated by the enrollee.

2-3.11 Coverage of Sterilizations, Abortions and Hysterectomies

The CONTRACTOR shall cover sterilizations, abortions and hysterectomies pursuant to applicable federal and state laws and regulations. When coverage requires the completion of a specific form, the form must be properly completed as described in the instructions with the original form maintained in the enrollee's medical file and a copy submitted to the CONTRACTOR for retention in the event of audit. Failure to follow applicable regulations and properly complete and maintain specific forms as required shall result in the assessment of damages in the amount of \$500 per violation, or the actual amount of the federal penalty created by the violation, whichever is greater. The following are applicable current policies:

2-3.11.1 Sterilizations

- a. Sterilization shall mean any medical procedure, treatment or operation done for the purpose of rendering an individual permanently incapable of reproducing.
- b. The individual to be sterilized shall give informed consent not less than thirty (30) full calendar days (or not less than 72 hours in the case of premature delivery or emergency abdominal surgery) but not more than one hundred eighty (180) calendar days before the date of the sterilization.
- c. The individual to be sterilized is at least twenty-one (21) years old at the time consent is obtained.

- d. The individual to be sterilized is mentally competent.
- e. The individual to be sterilized is not institutionalized; i.e., not involuntarily confined or detained under a civil or criminal status in a correctional or rehabilitative facility or confined in a mental hospital or other facility for the care and treatment of mental illness, whether voluntarily or involuntarily committed.
- f. The individual has voluntarily given informed consent on the approved "STERILIZATION CONSENT FORM" which is contained in this Agreement as Attachment V.

2-3.11.2 Abortions

- a. Abortion and services associated with the abortion procedure shall be covered only if the pregnancy is the result of an act of rape or incest; or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.
- b. A "CERTIFICATION OF MEDICAL NECESSITY FOR ABORTION" form, contained in this Agreement as Attachment VI, must be completed.

2-3.11.3 Hysterectomy

- a. Hysterectomy shall be covered when medically necessary.
- b. The individual or her authorized representative, if any, must be informed orally and in writing that the hysterectomy will render the individual permanently incapable of reproducing.
- c. The individual or her authorized representative, if any, must sign and date a "STATEMENT OF RECEIPT OF INFORMATION CONCERNING HYSTERECTOMY" form, contained in this Agreement as Attachment VII, prior to the hysterectomy. Informed consent must be obtained regardless of diagnosis or age.
- d. Hysterectomy shall not be covered if performed solely for the purpose of rendering an individual permanently incapable of reproducing.
- e. Hysterectomy shall not be covered if there was more than one purpose for performing the hysterectomy, but the primary purpose was to render the individual permanently incapable of reproducing.
- f. Hysterectomy shall not be covered if it was performed for the purpose of cancer prophylaxis.

2-3.12 Coverage of Organ Transplants

The CONTRACTOR shall cover at a minimum the following transplants: Renal, Heart, Liver, Corneal and Bone Marrow, when medically necessary and consistent with the accepted mode of treatment for which the transplant procedure is performed. The CONTRACTOR shall not cover transplants or procedures, which are not medically necessary or performed for a purpose inconsistent with acceptable modes of treatment. Besides the minimally required transplants, the CONTRACTOR may cover other transplants that are not considered investigational or experimental by the National Institutes of Health and the Tennessee Department of Finance and Administration, if approved by TennCare. For purposes of this Section, investigational or experimental shall mean those transplants and/or procedures which are not considered medically necessary and which have not been approved by the Health Care Financing Administration and published in the Federal Register. Questions as to whether a particular transplant and/or procedure is to be covered shall be directed to the Office of the Medical Director, Bureau of TENNCARE.

Exceptions to the above list of transplants must be made for other non-investigational/non-experimental transplants if the transplant and/or procedure is found to be medically necessary, performed within the accepted mode of treatment for which it is intended, and is found to be cost effective as determined by the CONTRACTOR.

The CONTRACTOR shall establish administrative procedures regarding the necessity of prior approval before a transplant procedure is performed. The CONTRACTOR shall also establish its own administrative procedures regarding the coverage of transplant procedures performed outside the CONTRACTOR's service area as well as transplant procedures performed out-of-state. These administrative procedures shall be submitted to TennCare for review and approval prior to use.

Section 1862 of the Social Security Act requires Medicare beneficiaries to have transplants performed in Medicare certified centers. In accordance with this policy, the CONTRACTOR and Medicare/TennCare dually eligible enrollees shall be required to adhere to these requirements.

2-3.13 Use of a Drug Formulary

The CONTRACTOR shall be required to cover pharmacy services as a benefit pursuant to this Agreement and the TennCare rules and regulations for those eligible populations as described by TENNCARE. This coverage may be accomplished by the use of an open formulary (whereby all drugs are covered) or by use of a closed formulary (whereby only designated drugs are covered). If coverage is pursuant to a closed formulary, the formulary and any subsequent additions or deletions to the formulary must be prior approved by the TennCare Pharmacy Director. Approval of a closed formulary will not be granted if it is determined that the formulary is too restrictive or fails to provide for medically necessary drugs. Formularies, whether open or closed, shall not include DESI, LTE or IRS drugs. Approval or disapproval of formularies and subsequent additions and deletions thereto shall be made in accordance with TennCare policy and procedures. The CONTRACTOR shall adhere to the following provisions:

- a. When medically necessary TennCare covered pharmacy benefits have been received during a period that an enrollee or provider could not have reasonably known what MCO the enrollee was in, the MCO shall not deny medically necessary pharmacy benefits for lack of prior authorization or as non-covered benefits when the medically necessary pharmacy benefits would be considered TennCare covered benefits except for the fact that they are not included on the CONTRACTOR's closed drug formulary.
- b. If coverage is pursuant to a closed formulary, an up-to-date copy of the complete formulary and a complete description of prior authorization criteria for each drug requiring prior authorization must be submitted via an electronic file to the TennCare Pharmacy Director in a format specified by the TennCare Pharmacy Director by January 1 of each year. TENNCARE shall provide the format for this file no later than November 1 of each year.
- c. Authorization of drugs, including prior approvals of formulary drugs and medical necessity reviews of non-formulary drugs, or denial of authorization of drugs shall be rendered by the CONTRACTOR or its subcontractor on the day of the formal request for authorization. If a CONTRACTOR or its subcontractor is unable to respond to a prior approval or medical necessity review request on the day of the request or if the prescriber is unavailable, the CONTRACTOR must provide a two (2) week supply of the prescribed medication, provided that:
 - (1) The medication is not classified by the Food and Drug Administration as Less Than Effective (i.e., a DESI, LTE or IRS drug), or
 - (2) The medication is not a drug in a non-covered TENNCARE therapeutic category (e.g., appetite suppressants, drugs to treat infertility), or
 - (3) Use of the medication is not contraindicated because of the patient's medical condition or possible adverse drug interaction, or
 - (4) If the patient is not already taking the medication, use of the medication for a two (2) week period possibly followed by abrupt discontinuance of the drug would not be medically contraindicated, or

- (5) The prescriber did not prescribe a total quantity less than a two (2) week supply, in which case the pharmacist must provide a supply up to the amount prescribed, or
- (6) Provision of the two (2) week supply would not violate state or federal Controlled Substances laws.

In some circumstances it is not feasible for the pharmacist to dispense a two (2) week supply because the drug is packaged by the manufacturer to be sold as the original unit or because the usual and customary pharmacy practice would be to dispense the drug in the original packaging. Examples would include but not be limited to inhalers, eye drops, ear drops, injections, topicals (creams, ointments, sprays), drugs packaged in special dispensers (birth control pills; steroid dose packs), and drugs that require reconstitution before dispensing (antibiotic powder for oral suspension). When a coverage of a two (2) week supply of a prescription would otherwise be required and when, as described above, it is not feasible for the pharmacist to dispense a two (2) week supply, it shall be the responsibility of the MCO to provide coverage for the amount prescribed.

Failure to provide a two (2) week supply of the prescribed medication as described above shall result in liquidated damages as described in Section 6-8 of this Agreement.

- d. Comply with the requirements of the TennCare Drug Formulary Accountability Act.
- e. MCOs shall not deny or withhold payment to any pharmacy for duplicate prescription refills, or prescriptions that are filled early in relation to the prior day's supply dispensed, where such refills are for the purpose of replacing an enrollee's lost or destroyed medication or providing an enrollee with the quantity of medication necessary for extended travel away from the community in which the enrollee resides, or for any other bona fide reason that causes the enrollee to be without a medication, when the discontinuation of the medicine would, in the pharmacist's professional judgment, place the enrollee at risk of harm. Provision of such duplicate prescription refills or early refills shall comply with applicable state and federal Controlled Substances laws and other state pharmacy laws and regulations.
- f. MCOs that impose a limit on the number of units of a medication that an enrollee can obtain per month without a medical necessity override shall have policies and procedures that permit the prescribing physician to request a medical necessity override upon submission of medical justification and that also permit a pharmacist to request an override to allow early dispensing, when in the pharmacist's professional judgment, the enrollee is not abusing the medication and needs early dispensing of the medication due to lack of readily accessible transportation.

2-3.14 Emergency Medical Services

The CONTRACTOR must review and approve or disapprove claims for emergency medical services based on the definition of emergency medical services specified in Section 1-3 of this Agreement. The CONTRACTOR shall provide coverage for inpatient and outpatient services, furnished by a qualified provider, regardless of whether the enrollee obtains the services from a network provider, that are needed to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard without prior authorization in accordance with 42 C.F.R. § 422.113. Once the individual's condition is stabilized, the CONTRACTOR shall require notification or apply applicable utilization management processes specified in Section 2-7.1 for hospital admission or follow-up care. The CONTRACTOR shall base coverage decisions for emergency medical services on the severity of the symptoms at the time of presentation and shall cover emergency medical services where the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. The CONTRACTOR shall impose no restrictions on coverage of emergency medical services more restrictive than those permitted by the prudent layperson standard.

If an emergency screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition exists, the CONTRACTOR shall pay for both the services involved in the screening examination and the services required to stabilize the patient. The CONTRACTOR shall be required to pay for all emergency medical services, which are medically necessary until the clinical emergency is stabilized. This includes all medical services that may be necessary to assure, within reasonable medical probability, that no material deterioration of the patient's condition is likely to result from, or occur during, discharge of the patient or transfer of

the patient to another facility. If there is a disagreement between the hospital and the CONTRACTOR concerning whether the patient is stable enough for discharge or transfer, or whether the medical benefits of an unstabilized transfer outweigh the risks, the judgment of the attending physician(s) actually caring for the patient at the treating facility prevails and is binding on the CONTRACTOR. The CONTRACTOR, however, may establish arrangements with a hospital whereby the CONTRACTOR may send one of its own physicians with appropriate emergency room privileges to assume the attending physician's responsibilities to stabilize, treat, and transfer the patient, provided that such arrangement does not delay the provision of emergency medical services.

The CONTRACTOR shall not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergency in nature. If an emergency screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition does not exist, then the determining factor for payment liability shall be whether the patient had acute symptoms of sufficient severity at the time of presentation. In such cases, the CONTRACTOR shall review the presenting symptoms of the patient and shall pay for all services involved in the screening examination where the presenting symptoms (including severe pain) were of sufficient severity to have warranted emergency attention under the prudent layperson standard regardless of final diagnosis.

When the patient's primary care provider instructs the patient to seek emergency care, the CONTRACTOR shall be responsible for payment for the medical screening examination and for other medically necessary emergency medical services, without regard to whether the patient meets the prudent layperson standard.

2-3.15 Prenatal Care

The CONTRACTOR shall have policies and procedures to facilitate and take reasonable steps to assist pregnant members in accessing prenatal care. This provision shall apply to enrollees in the plan who become pregnant as well as enrollees who are pregnant on the beginning date of enrollment in the plan. This provision does not intend to require all of the CONTRACTOR's network providers to accept new enrollees. However, the CONTRACTOR shall maintain a provider network consisting of providers who accept new enrollees in accordance with TennCare access standards and shall inform TENNCARE, as required, of network providers who do not accept new enrollees. In the event an enrollee entering the CONTRACTOR's plan is receiving medically necessary prenatal care services the day before enrollment, the CONTRACTOR shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided within or outside the CONTRACTOR's provider network until such time as the CONTRACTOR can reasonably transfer the enrollee to a service and/or network provider without impeding service delivery that might be harmful to the enrollee's health. The CONTRACTOR shall require, as a condition of payment, that the service provider accept the amount paid by the CONTRACTOR or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payor) plus any applicable amount of cost sharing responsibilities due from the enrollee as payment in full for the service.

The CONTRACTOR shall provide medically necessary medical care to their enrollees beginning on the date of their enrollment in the MCO's plan. This requirement includes not only TennCare enrollees whose eligibility is established through SSI, Medicaid or uninsured/uninsurable applications for TennCare, but also those pregnant women who establish "presumptive eligibility" for TennCare. Effective with the first day of a presumptive eligibility period, the State makes payments on behalf of these women to the selected MCO and the MCO is required to provide medical care for their enrollee during this period.

Women who are presumptively eligible are entitled to all TennCare benefits. There shall be a sufficient number of providers in the MCO's network who accept enrollees within each geographical location in which the plan is marketed so that prenatal or other medically necessary medical care is not delayed or denied to these women during their presumptive eligibility period. Additionally, the MCO must make services available out-of-plan, if necessary, to meet the medical needs of a woman enrolled in the MCO's plan as a presumptive eligible.

The CONTRACTOR shall notify all network providers that any unreasonable delay in providing care to a pregnant member seeking prenatal care will be considered a material breach of the network provider's contract with the CONTRACTOR. Delay in care for pregnant enrollees shall mean:

1. Failure of the MCO to respond to an enrollee's request for prenatal care by identifying a maternity care provider to honor a request from an enrollee, including a presumptive eligible enrollee, (or from a primary care provider or patient advocate acting on behalf of an enrollee) for a prenatal care appointment. Accessibility shall be in accordance with the Terms and Conditions for Access to the TennCare Waiver and contained herein as Attachment III unless TENNCARE shall specify more stringent access criteria. Regardless of whether prenatal care is provided by a primary care physician, physician extender or an obstetrician who is not the enrollee's primary care physician, the access standards for primary care physician or extender services shall apply when determining access to prenatal care except for cases of a first prenatal care appointment for women who are past their first trimester of pregnancy on the day they are determined to be eligible. For women who are past their first trimester of pregnancy on the day they are determined to be eligible, a first prenatal care appointment shall occur within fifteen (15) days of the day they are determined to be eligible; or
2. Failure of a pharmacist within the MCO's provider network to fill a prescription written by a maternity care provider for an enrollee, including an approved presumptive eligible, within the specified time frames for all medically necessary requests as described elsewhere in this Agreement and/or the TennCare rules and regulations.

The CONTRACTOR shall maintain a prenatal care program for high risk maternity cases designed to increase the likelihood of positive birth outcomes.

Failure to provide prenatal care in accordance with the provisions described herein shall result in the CONTRACTOR being required to implement a corrective action plan as described in Section 2-16, and shall result in the application of liquidated damages and/or intermediate sanctions as described in Section 6.8 of this Agreement.

2-4 Service Delivery Requirements

The CONTRACTOR shall administer the benefits specified in this Agreement in accordance with the provisions specified below.

2-4.1 Availability and Accessibility of Services

The CONTRACTOR must provide or arrange for the provision of all of the services described as covered in this Agreement. The CONTRACTOR shall make services, service locations, and service sites available and accessible to provide the covered (specialized or otherwise) services. Accessibility shall be in accordance with the Terms and Conditions for Access which is part of the TennCare Waiver and as contained herein as Attachment III unless TENNCARE has specified more stringent access criteria in the Agreement or the Amendments thereto. The CONTRACTOR must provide or arrange for the provision of all the services described as covered in this Agreement.

The CONTRACTOR shall maintain under contract, a provider network including but not limited to primary care physicians, specialist physicians, nurse practitioners/physician assistants, hospitals (all levels primary, secondary and tertiary), centers of excellence, nursing homes, laboratories, pharmacies and all other health care facilities necessary to provide TennCare covered benefits.

2-4.1.1 Primary Care Services

The CONTRACTOR shall assure that there are primary care providers, willing and able to provide the level of care and range of services necessary to meet the medical needs of the enrollees including those with chronic and acute diseases. There shall be a sufficient number of primary care providers who accept new TennCare enrollees within each geographical location in which the plan is marketed so that each primary care provider has a reasonable caseload. Primary care providers shall be strategically located so that no enrollee shall be required to travel more than thirty (30) miles or thirty (30) minutes one-way, whichever is less, to a primary care provider. If an enrollee requests assignment to a primary care provider located outside the distance/time requirements and the CONTRACTOR has primary care providers available within the distance/time requirements who accept new enrollees, it shall not be considered a violation of the access

requirements for the CONTRACTOR to grant the enrollee's request. However, in such cases the CONTRACTOR shall have no responsibility for providing transportation for the enrollee to access care from this selected provider and the CONTRACTOR shall so notify the enrollee in writing as to whether or not the CONTRACTOR will provide transportation for the enrollee to seek care from the requested provider. In these cases of out-of-area assignment, the CONTRACTOR must allow the enrollee to change assignment to a primary care provider within the distance/time requirements if the enrollee requests such a change.

2-4.1.2 Specialty Services

The CONTRACTOR shall demonstrate sufficient availability and accessibility to Specialty Services for TennCare enrollees (Specialty Services includes Essential Hospital Services, services provided by Centers of Excellence, and specialty physician services). Sufficient availability and accessibility will be defined as meeting or exceeding the Terms and Conditions of the TennCare waiver as described in Attachment III. The CONTRACTOR shall also comply with the standards and measures specified in this section to demonstrate sufficient availability and accessibility of Specialty Services for TennCare enrollees.

TENNCARE shall take geography, the usual and customary practices, and timely access to quality care into account when reviewing the CONTRACTOR's Specialty Services network. If TENNCARE or the CONTRACTOR identifies a deficiency in the Specialty Services network, the CONTRACTOR shall develop a corrective action plan to address the deficiency and an explanation of how TennCare members will receive access to such services while the network deficiency exists. If the CONTRACTOR fails to correct the deficiency in a timely manner, TENNCARE may impose intermediate sanctions as described in Section 6.8.

a. Essential Hospital Services. The CONTRACTOR shall demonstrate sufficient access to Essential Hospital Services, including but not limited to:

- (1) neonatal services
- (2) perinatal services
- (3) pediatric
- (4) trauma
- (5) burn

b. Centers for Excellence. The CONTRACTOR shall demonstrate sufficient access to Centers of Excellence for:

- (1) People with AIDS
- (2) Children in, or at risk of, state custody

In each Grand Region, the CONTRACTOR shall demonstrate a contractual arrangement with at least one (1) Tertiary Care Center for each of the essential hospital services and at least one (1) Center of Excellence for People with AIDS. The CONTRACTOR shall demonstrate a contractual arrangement with all Centers of Excellence for children in, or at risk of state custody, as identified by TennCare. This minimum requirement is not intended to release the CONTRACTOR from the requirement to provide or arrange for the provision of any covered service required by its enrollees, whether specified above or not.

To demonstrate sufficient availability and accessibility of Essential Hospital Services and Centers of Excellence, the CONTRACTOR shall complete the "Essential Hospital Services Chart" in Attachment XII, Exhibit D within 60 days of Agreement execution, and by September 1 thereafter of each year for each of the Grand Regions in which it operates for TennCare. In each Grand Region, the CONTRACTOR shall demonstrate a contractual arrangement with at least one (1) Tertiary Care Center for each of the essential hospital services and at least one (1) Center of Excellence for People with AIDS.

c. Specialty Physicians. The CONTRACTOR shall demonstrate sufficient access to Physician Specialists, including but not limited to:

- (1) cardiology
- (2) orthopedics

- (3) otolaryngology
- (4) urology
- (5) neurology
- (6) gastroenterology
- (7) neurosurgery
- (8) ophthalmology
- (9) oncology/hematology

The CONTRACTOR shall establish and maintain a network of physician specialists who accept new TennCare enrollees, adequate and reasonable in number, in specialty, and in geographic distribution to meet the medical needs of its enrollees (adults and children) without excessive time and travel requirements, whether specified above or not. Specialist services must be available on at least a referral basis.

To demonstrate sufficient availability and accessibility of Specialty Physician services, the CONTRACTOR shall submit the monthly provider file of contracted providers as required by Attachment XII, Exhibit C and, within sixty (60) days of Agreement execution, and by September 1 thereafter each year submit the "Specialty Physician Services Chart" as required by Attachment XII, Exhibit E for each of the CSAs in which it operates for TennCare. This Specialty Physician Services chart should indicate all non-contractual arrangements that the CONTRACTOR has with Specialty Physicians in each CSA. TENNCARE expects that the CONTRACTOR will make best efforts to contract with providers to whom the CONTRACTOR routinely refers enrollees.

In order to satisfy time/distance travel requirements and support community referral patterns, the CONTRACTOR shall establish provider agreements with each of the nine physician specialists identified in (3) above in each area designated by TennCare as a focal point for specialist services in the CONTRACTOR's service area within ninety (90) days of Agreement execution, as specified in Attachment IV. A sufficient number of provider agreements shall be established in each focal point to ensure that non-dual Medicare/Medicaid enrollee to provider ratios remain below the maximum allowable ratios for each area as defined in Attachment IV. In addition to establishing provider agreements in each of the required focal points, the CONTRACTOR agrees to pursue network development efforts in each priority area identified in Attachment IV with the understanding that twelve (12) months after the effective date of this Agreement, TennCare may designate priority areas as additional required contract areas.

TENNCARE will review the "Specialty Physician Services Chart" in conjunction with the monthly provider files submitted by the CONTRACTOR and other information regarding complaints or appeals for specialty services to determine whether or not the CONTRACTOR's Specialty Services network and out-of-network arrangements are sufficient to demonstrate timely availability and accessibility of quality care.

If TENNCARE or the CONTRACTOR identifies a deficiency in the Specialty Services network, the CONTRACTOR shall develop a corrective action plan to address the deficiency and an explanation of how TennCare members will receive access to such services while the network deficiency exists. If the CONTRACTOR fails to correct the deficiency in a timely manner, TENNCARE may impose intermediate sanctions as described in Section 6-8, unless the CONTRACTOR provides sufficient documentation to demonstrate that the deficiency is attributable to a lack of specialty physician supply in the area.

TENNCARE shall not request that the CONTRACTOR submit the "Specialty Physician Services Chart" more frequently than annually unless TENNCARE has reason to believe that the CONTRACTOR's physician specialty network has significantly changed or that the CONTRACTOR does not have sufficient availability or accessibility of such specialty service in such CSA(s).

2-4.1.3 Emergency Medical Services

Emergency medical services shall be available twenty-four (24) hours a day, seven (7) days a week.

2-4.2 Primary Care Providers

The CONTRACTOR shall provide or arrange for the provision of primary care case management services to TennCare eligible enrollees. The CONTRACTOR shall be responsible for the management of medical care and continuity of care for all its TennCare enrollees. Primary care case management services include the management of medical care and continuity of care for TennCare enrollees.

- a. To the extent feasible and appropriate, the CONTRACTOR agrees to offer each enrollee a choice of a primary care provider.
- b. The CONTRACTOR shall establish policies and procedures to enable enrollees reasonable opportunities to change primary care providers. Such policies and procedures may not specify a length of time greater than twelve (12) months between changes under normal circumstances. If a time restriction for change is imposed, the CONTRACTOR must include provisions for more frequent changes with good cause.
- c. Primary care providers may include licensed physicians as well as registered professional nurses and physician assistants practicing in accordance with state law.
- d. Each enrollee must have an identified primary care provider with the exception of the dually eligible Medicare/Medicaid enrollees. If an enrollee is not dually eligible for Medicare and Medicaid and fails or refuses to select a primary care provider from those offered within thirty days of enrollment, the CONTRACTOR shall assign a primary care provider. The CONTRACTOR may assign a PCP in less than thirty (30) days if the CONTRACTOR provides the enrollee an opportunity to change PCPs upon receipt of notice of PCP assignment.
- e. Children in state custody shall be assigned to a Best Practice Network Primary Care Provider as specified in Section 3 of this Agreement.
- f. Additionally, other vulnerable populations (e.g., persons with special needs such as multiple handicaps, or acute chronic conditions, etc.) may be assigned to a case manager at the MCO level or, at the MCO's discretion, to their attending specialist as their primary care provider.

2-4.3 Management of Medical Care and Coordination of Care

The CONTRACTOR shall be responsible for the management of medical care and continuity of care for all its TennCare enrollees through the following minimum functions:

- a. Performance of reasonable preventive health case management services described in the Quality of Care Monitors, included in this Agreement as Attachment II, and appropriate referral, outreach and scheduling assistance of enrollees needing specialty health care services, including those identified through the provision of preventive services;
- b. Documentation of referral services in enrollees' medical records;
- c. Monitoring of enrollees with ongoing medical conditions;
- d. Documentation in the medical record of enrollee emergency encounters with appropriate medically indicated follow-up;
- e. Coordinated hospital and/or institutional discharge planning that includes post-discharge care, as appropriate;
- f. Maintenance of its own internal tracking system which identifies the current preventive services screening status and pending preventive services screening due dates for each enrollee. The Contractor agrees to assist in the development of a tracking system that will identify EPSDT screens, immunizations and lab tests due, dates of service for all EPSDT screens, immunizations and lab tests received, referrals for

corrective treatment, whether corrective treatment was provided, and dates of service for corrective treatment and agrees to pilot said system when developed;

- g. Authorization of out-of-plan or out-of-state services which are medically necessary due to an emergency;
- h. Assistance in the coordination of mental health and medical care of enrollees as described in Section 2-3.5 of this Agreement;
- i. In the event an enrollee entering the MCO's plan is receiving medically necessary TennCare covered services the day before enrollment, the CONTRACTOR shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided within or outside the CONTRACTOR's provider network until such time as the CONTRACTOR can reasonably transfer the enrollee to a service and/or network provider without impeding service delivery that might be harmful to the enrollee's health. The CONTRACTOR shall assure that the enrollee is held harmless by the provider for the costs of the service or procedure except for applicable cost sharing amounts. The CONTRACTOR shall require, as a condition of payment, that the service provider accept the amount paid by the CONTRACTOR or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payer) plus any applicable amount of cost sharing due from the enrollee as payment in full for the service. If the CONTRACTOR's payment to a non-contract provider is less than it would have been for a contract provider and the provider contests the payment amount, the CONTRACTOR shall notify the non-contract provider that the provider may initiate the independent review procedures in accordance with T.C.A. Section 56-32-226 as described in Section 2-18 of this Agreement. If it is medically necessary that care extend beyond thirty (30) days, the CONTRACTOR may require prior authorization for continuation of the services beyond thirty (30) days. Care rendered to a CONTRACTOR's enrollee beyond thirty (30) days that is out-of-plan or out-of-network for which a provider has not sought prior authorization need not be reimbursed;
- j. In the event an enrollee entering the CONTRACTOR's plan is receiving medically necessary prenatal care services the day before enrollment, the CONTRACTOR shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided within or outside the CONTRACTOR's provider network until such time as the CONTRACTOR can reasonably transfer the enrollee to a service and/or network provider without impeding service delivery that might be harmful to the enrollee's health. The CONTRACTOR shall require, as a condition of payment, that the service provider accept the amount paid by the CONTRACTOR or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payer) plus any applicable amount of cost sharing responsibilities due from the enrollee as payment in full for the service.
- k. In the event of a dental carve-out, the CONTRACTOR agrees to provide assistance as requested by TENNCARE to support the transition of dental services to a new provider.

2-4.4 Referrals and Exemptions

The CONTRACTOR shall require enrollees to seek a referral from their PCP or case manager prior to accessing non-emergency specialty services in accordance with, the following provisions:

- a. The CONTRACTOR shall exempt routine dental services for children under age 21 from case manager or PCP referral.
- b. The CONTRACTOR shall allow an enrollee at least one (1) annual preventive care visit to a network obstetrician/gynecologist without obtaining a referral from a case manager or a primary care provider.
- c. The CONTRACTOR may exempt enrollees from case manager or PCP referral in order to obtain prenatal care from an obstetrician when the enrollee's PCP does not provide prenatal and delivery services. However, if the CONTRACTOR requires a referral in order to obtain prenatal care, the CONTRACTOR shall not require the enrollee to go for an office visit with their PCP in order to obtain the referral.

- d. The CONTRACTOR may exempt routine vision services from case manager or PCP referral.
- e. The CONTRACTOR shall provide all PCPs and Case Managers with a current listing of referral providers. The CONTRACTOR shall supply this listing to all PCPs and Case Managers within thirty (30) days of the effective date of this Agreement. A supplemental listing indicating additions and deletions shall be provided on a quarterly basis thereafter. Quarterly basis for purposes of mailing the supplemental listings shall be based on a calendar year schedule (e.g., Jan. – March, etc.) and two (2) copies shall be sent to TennCare as proof of compliance by the 30th of the month following each quarter in accordance with the reporting schedules as described in Section 6-8 of this Agreement.
- f. The CONTRACTOR shall support appropriate referral, outreach and scheduling assistance of enrollees needing specialty health care services when requested by providers or as specified in Section 3.

2-4.5 Abusive Utilizers of Pharmacy Services

The CONTRACTOR shall require that individuals identified by TENNCARE or the CONTRACTOR as abusive utilizers of pharmacy services be restricted to using a single primary care provider and a single pharmacy provider for non-emergency services. The CONTRACTOR may submit an alternative method to accomplish this provision for TENNCARE approval. Enrollees who disagree with such restrictions may appeal such restrictions pursuant to the medically necessary provisions of the TennCare hearing rules.

2-4.6 Network Notice Requirements

The CONTRACTOR shall provide notice of changes to its provider network as specified below.

2-4.6.1 Enrollee Notification

- a. Change in PCP. Written notice shall be given immediately to an enrollee by the CONTRACTOR when a change in the enrollee's PCP is made. The notice shall be issued in advance of the PCP change when possible or as soon as the CONTRACTOR becomes aware of the circumstances. The notice content shall be consistent with the notice template provided by TennCare.
- b. PCP Termination. If a PCP ceases participation, the CONTRACTOR shall immediately provide written notice, which shall be considered to be no less than thirty (30) days prior to the effective date of the termination, to each enrollee who has chosen the provider as their PCP. Each notice shall include all components identified in the notice template provided by TennCare. The requirement to provide notice thirty (30) days prior to the effective date of termination shall be waived in instances where a provider becomes physically unable to care for members due to illness, a provider dies, the provider fails to provide thirty (30) days advance notice to the CONTRACTOR, the provider moves from the service area and fails to notify the CONTRACTOR or when a provider fails credentialing, and instead shall be made immediately upon the CONTRACTOR becoming aware of the circumstances.
- c. Providers Providing On-going Treatment. If an enrollee is in a prior authorized ongoing course of treatment with any other participating provider who becomes unavailable to continue to provide services to such enrollee and the CONTRACTOR is aware of such ongoing course of treatment, the CONTRACTOR shall immediately provide written notice within fifteen (15) calendar days from the date that the CONTRACTOR becomes aware of such unavailability to such enrollee. Each notice shall include all components identified in the notice template provided by TennCare. The timing requirement for the provision of this notice shall be waived in instances where a provider becomes physically unable to care for members due to illness, a provider dies, the provider moves from the service area and fails to notify the CONTRACTOR or when a provider fails credentialing, and instead shall be made immediately upon the CONTRACTOR becoming aware of the circumstances.

- d. Non-PCP Provider Termination. If a non-PCP ceases participation in the MCO, the CONTRACTOR shall immediately provide written notice to enrollees who have been patients of the non-PCP provider. Each notice shall include all components identified in the notice template provided by TennCare. Notice shall be issued in advance of the non-PCP provider termination when possible or immediately upon the CONTRACTOR becoming aware of the circumstances.
- e. Network Deficiency. Upon final notification from TENNCARE of a network deficiency, which shall be based on the requirements of this Agreement and terms and conditions of the waiver (Attachment III), the CONTRACTOR shall immediately provide written notice to enrollees living in the affected area of a provider shortage in the CONTRACTOR's network. The notice content shall be consistent with the notice template provided by TennCare.

2-4.6.2 TennCare Notification

- a. Notice of Subcontractor Termination. When a subcontract that relates to the provision of services to enrollees or claims processing is being terminated between the CONTRACTOR and a subcontractor, the CONTRACTOR shall give at least thirty (30) days prior written notice of the termination to TENNCARE and the TennCare Division, TDCI. Said notices shall include, at a minimum; a CONTRACTOR's intent to change to a new subcontractor for the provision of said services, an effective date for termination and/or change, as well as any other pertinent information that may be needed to access services. In addition to prior written notice, the CONTRACTOR shall also provide TENNCARE with a transition plan, when requested, which shall include, at a minimum, information regarding how prior authorization requests will be handled during and after the transition, how continuity of care will be maintained for the enrollees, etc.
- b. Hospital Termination. Termination of the CONTRACTOR's provider agreement with any hospital, whether or not the termination is initiated by the provider or by the CONTRACTOR, shall be reported by the CONTRACTOR in writing to the Bureau of TennCare no less than thirty (30) calendar days prior to the effective date of the termination.
- c. Other Provider Terminations. The CONTRACTOR shall notify TennCare of any provider termination and submit a template copy of the enrollee notice sent as well as an electronic listing identifying each enrollee to whom a notice was sent as required in Section 2-4.6.1. The CONTRACTOR shall maintain a copy of the actual notice on-site and forward a copy of the notices upon request from TENNCARE. If the termination was initiated by the provider, said notice shall include a copy of the provider's notification to the Contractor.

Furthermore, if termination of the CONTRACTOR's provider agreement with any primary care provider or physician group or clinic, whether or not the termination is initiated by the provider or by the CONTRACTOR, places the CONTRACTOR out of compliance with Section 2-4, such termination shall be reported by the CONTRACTOR in writing to the Bureau of TennCare, in the standard format used to demonstrate compliance with provider network and access requirements, within five (5) working days of the date that the agreement has been terminated.

2-4.7 Out of Area or Out of Plan Use

The CONTRACTOR shall notify and advise all enrollees of the provisions governing out of plan use, including the use of non-contract providers and the use of providers outside the community service area.

2-4.7.1 Emergency Medical Services obtained from Out of Plan Providers

The CONTRACTOR's plan shall include provisions governing utilization of and payment by the CONTRACTOR for emergency medical services received by an enrollee from non-contract providers, regardless of whether such emergency services are rendered within or outside the community service area covered by the plan. Coverage of emergency medical services shall not be subject to prior authorization by the CONTRACTOR. The CONTRACTOR may include a requirement that notice be given by the provider to the CONTRACTOR of use of out-of-plan emergency services; however, such notice requirements shall

provide at least a twenty-four (24) hour time frame after the emergency for notice to be given. If the CONTRACTOR does not provide twenty-four (24) hour a day access for such notice, the notice requirements shall provide at least a twenty-four (24) hour time frame from the next business day after the emergency for notice to be given. Utilization of and payments to non-contract providers may, at the CONTRACTOR's option, be limited to the treatment of emergency medical conditions, including medically necessary services rendered to the enrollee until such time as he/she can be safely transported to an appropriate contract service location. Payment amounts shall be consistent with the pricing policies developed by the CONTRACTOR for emergency out-of-plan services. Payment by the CONTRACTOR for properly documented claims for emergency medical services rendered by a non-contract provider shall be made within thirty (30) calendar days of receipt of a clean claim by the CONTRACTOR.

The CONTRACTOR must review and approve or disapprove claims for emergency medical services based on the definition of emergency medical services specified in Section 1-3 of this Agreement. If the CONTRACTOR determines that a claim requesting payment of emergency medical services does not meet the definition as specified in Section 1-3 and subsequently denies the claim, the CONTRACTOR shall notify the provider of the denial. This notification shall include information to the provider regarding the CONTRACTOR's process and timeframes for reconsideration and subsequent steps regarding an informal review by TENNCARE. In the event a provider disagrees with the CONTRACTOR's decision to disapprove a claim for emergency medical services, the provider may request an informal review by TENNCARE after having exhausted all steps in the CONTRACTOR's plan for the resolution of such disputes. Said request for an informal review by TENNCARE shall be made within 180 days from the date of service with the exception of instances of retroactive eligibility or circumstances beyond a provider's control such as the involvement of a third party payer. As the result of the informal review, if TENNCARE determines the claim should be allowed, the CONTRACTOR shall make payment for the claim. After informal review, if TENNCARE determines the CONTRACTOR's denial was correct, the provider shall have the right to request a formal hearing, pursuant to T.C.A. Section 71-5-113, on the matter within fifteen (15) calendar days of the decision. All requests for a formal hearing from providers for emergency medical service claims denied by the CONTRACTOR must be submitted in writing to TENNCARE for review and final determination. TENNCARE's decision in such matters shall not be rendered arbitrarily but shall be based upon the facts at hand and the applicability of the various requirements of this Agreement. The CONTRACTOR agrees to pay previously denied emergency medical service claims if the decision by TENNCARE is to honor the claim.

2-4.7.2 MCO Assignment Unknown – Services Obtained from Out-of-Plan Provider

The CONTRACTOR shall include provisions governing the payment for medically necessary covered services provided to an enrollee by a non-contract or non-referred provider for services received by an enrollee any time when TENNCARE determines that the enrollee is eligible for TennCare and has enrolled the individual in the CONTRACTOR's plan and the enrollee could not have known which MCO they were enrolled in at the time of the service. The parties to this Agreement recognize that in accordance with TennCare policies and procedures, if an enrollee requests enrollment in a specified MCO, the enrollee may be assigned to an MCO other than the one that he/she requested. An example of circumstances when an enrollee would not be enrolled in the requested MCO includes, there is not sufficient capacity in the MCO in which the enrollee requested enrollment. If an enrollee did not request enrollment in a specified MCO, the enrollee will be assigned to an MCO in accordance with TennCare policies and procedures. In either case, the effective date of enrollment may occur prior to the MCO being notified of the enrollee becoming a member of the plan. When this situation arises, the MCO shall not deny medically necessary services provided during this period of eligibility for lack of prior authorization or lack of referral; likewise, an MCO shall not deny a claim on the basis of the provider's failure to file a claim within a specified time period after the date of service when the provider could not have reasonably known which MCO the enrollee was in during the timely filing period. However, in such cases the MCO may impose timely filing requirements beginning on the date of notification of the individual's enrollment. When an enrollee has incurred medically necessary medical expenses that are covered benefits during a period of enrollment in the plan, the CONTRACTOR shall make reimbursement for the medical services and shall assure that the enrollee is held harmless by the provider for the costs of the service or procedure except for applicable cost sharing amounts. The CONTRACTOR shall require, as a condition of payment, that the service provider accept the amount paid by the CONTRACTOR or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payor) plus any applicable amount of cost sharing responsibilities due from the enrollee as payment in full for the service.

Failure to provide coverage of a service or make payments for a service within five (5) calendar days of a directive from TENNCARE shall result in the application of liquidated damages as described in Section 6-8 of this Agreement.

2-4.7.3 Medically Necessary Services obtained from Out of Plan Providers/Referred by Contract Provider

The CONTRACTOR shall include provisions governing the referral and payment for medically necessary services provided to an enrollee by a non-contract provider at the request of a contract provider. The CONTRACTOR's payment shall not be less than eighty percent (80%) of the rate that would have been paid by the plan if the enrollee had received the services from a provider who is participating in the CONTRACTOR's plan. The CONTRACTOR shall require the out-of-plan provider to accept the CONTRACTOR's payment, plus applicable cost sharing responsibilities as payment in full for the service(s) as required by TennCare rules and regulations and Section 2-3.1 of this Agreement.

2-4.7.4 Medically Necessary Services obtained from Out-of-Plan Providers/ Non-Referred

With the exception of circumstances described in Section 2-4.7.2 and 2-4.7.3 when an enrollee has utilized medically necessary non-emergency services available under the plan from a provider who was not enrolled as a participating provider in the CONTRACTOR's plan and the CONTRACTOR has not authorized such use in advance, the CONTRACTOR shall not pay for the service(s) received unless ordered to do so by an administrative law judge, the State or the Health Services Team (as specified in Section 3).

The CONTRACTOR shall not make payment to non-participating providers for services that are not medically necessary unless ordered to do so by an administrative law judge, the State or the Health Services Team (as specified in Section 3).

2-4.7.5 Services Ordered by Medicare Providers for Dual Eligibles

When a TennCare enrollee is dually eligible for Medicare and Medicaid and requires services that are covered by the plan but are not covered by Medicare, and the services are ordered by a Medicare provider who does not participate in the CONTRACTOR's plan, the CONTRACTOR must pay for the ordered service if it is provided by a contract provider. Reimbursement shall be at the same rate that would have been paid had the service been ordered by a contract provider. The CONTRACTOR shall not be liable for the cost of non-covered services or services which are not medically necessary or the cost of services ordered and obtained from non-contract providers.

In order to assure the TennCare/Medicare (dual population) enrollees assigned to TennCare MCOs continue to receive pharmacy services without interruption during the carve-out of their pharmacy benefits, each MCO is required to execute whatever measures are necessary with their subcontractor - pharmacy benefits manager (PBM) - so that a text message is sent to each dispensing pharmacy when a claim for a TennCare/Medicare enrollee is submitted to an MCO's PBM in error. The text message sent to the pharmacy must direct the pharmacy to submit the claim to the point-of-service, online pharmacy claims processor under contract to the TennCare Bureau to process pharmacy claims for TennCare/Medicare enrollees.

2-4.7.6 Credentialing of Non-Contract Providers

No CONTRACTOR shall regularly make reimbursement payments to non-contract providers for non-emergency services without subjecting those providers to the same credentialing and approval process required by TENNCARE for contract providers.

Non-contract providers who regularly receive payments from a MCO need not sign a contract with the MCO. However, if non-contract providers regularly used by the MCO do not voluntarily submit such credentials, or are not approved by TENNCARE, then the MCO shall make no further payments to them.

TENNCARE shall define to the CONTRACTOR those non-contract providers who are "regularly used by the MCO".

2-4.8 Compliance with the Clinical Laboratory Improvement Act (CLIA) of 1988

The Clinical Laboratory Improvement Act (CLIA) of 1988 requires that all laboratory-testing sites have either a CLIA certificate of waiver or a CLIA certificate of registration to legally perform testing in the United States.

The CONTRACTOR shall require that all laboratory testing sites providing services under this Agreement must have either a Clinical Laboratory Improvement Act (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificate of waiver will provide only the types of tests permitted under the terms of their waiver. Laboratories with certificate of registration may perform a full range of laboratory tests. The CONTRACTOR shall comply with the provisions of CLIA 1988.

2-4.9 Federally Qualified Health Centers (FQHCs) and Other Safety Net Providers

2-4.9.1 Federally Qualified Health Centers (FQHCs)

The CONTRACTOR is encouraged to contract for the provision of primary care services, preventive care services and/or specialty/referral services with Federally Qualified Health Clinics (FQHCs) and other safety net providers in the CONTRACTOR'S service area to the extent possible and practical. In addition, where FQHCs are not utilized, the MCO must demonstrate to the U.S. Department of Health and Human Services, the Tennessee Department of Human Services and to TENNCARE that both adequate capacity and an appropriate range of services for vulnerable populations exist to serve the expected enrollment in a service area without contracting with FQHCs. If the CONTRACTOR utilizes FQHCs for services, the CONTRACTOR is required to address cost issues related to the scope of services provided by FQHCs and shall reimburse FQHCs either on a capitated (risk) basis considering adverse selection factors or reimburse FQHCs on a fee-for-service, cost-related basis.

In accordance with the HCFA Terms and Conditions to the TennCare Waiver, FQHC reporting information shall be submitted to TENNCARE on an annual basis as described in Section 2-10.12 of this Agreement.

2-4.9.2 Local Health Departments

All MCOs participating in TennCare shall be required to contract with each Local Health Department for the provision of EPSDT services in the community service area(s) in which it is authorized to serve, until such time as the MCO achieves an adjusted periodic screening rate of eighty percent or greater. Effective July 1, 2001, the CONTRACTOR shall reimburse the Local Health Department at no less than the following rates:

<u>Preventive Visits</u>	<u>85% of 2001 Medicare</u>
99381 New pt. Up to 1 yr.	\$80.33
99382 New pt. 1- 4 yrs.	\$88.06
99383 New pt. 5 - 11yrs.	\$86.60
99384 New pt. 12 - 17yrs.	\$95.39
99385 New pt. 18 - 39 yrs.	\$93.93
99391 Estab.pt. Up to 1 yr.	\$63.04
99392 Estab.pt. 1 - 4 yrs.	\$71.55
99393 Estab.pt. 5 - 11yrs.	\$70.96
99394 Estab.pt. 12 - 17yrs.	\$79.57
99395 Estab.pt. 18 - 39 yrs.	\$78.99

On an annual basis, the required minimum reimbursement rate shall be updated to the equivalent of the prior year Medicare fee schedule for Tennessee multiplied by 85% and inflated with expected trend values as reported by Medicare. The CONTRACTOR agrees TENNCARE may conduct an audit of the MCO's reimbursement methodology and related processes on an annual basis to verify compliance with this requirement. In addition, the Local Health Department may initiate the independent review procedure at any time it believes the CONTRACTOR's payment is less than the required minimum reimbursement rate.

The provider agreement with the Local Health Department must meet the minimum requirements specified at Section 2-18 and must also specify for the purpose of EPSDT services: (1) that the Local Health Department agrees to submit encounter data timely to the CONTRACTOR; (2) that the CONTRACTOR agrees to timely process claims for services in accordance with Section 2-9.7; (3) that the Local Health Department may terminate the agreement for cause with thirty days advance notice; and (4) that the CONTRACTOR agrees prior authorization shall not be required for the provision of EPSDT services.

2-4.10 Cost-Sharing

The CONTRACTOR and all providers and subcontractors shall not require any cost sharing responsibilities for TennCare covered services except to the extent that cost sharing responsibilities are required for those services by TENNCARE in accordance with TennCare rules and regulations, nor may the CONTRACTOR and all providers and subcontractors charge enrollees for missed appointments.

Cost sharing responsibilities shall apply to services other than the preventive services described in Section 2-3.3 of this Agreement. Copayments shall be applied on a sliding scale according to the enrollee's income. The maximum out-of-pocket expenses an enrollee may incur as the result of cost sharing responsibilities shall also be limited according to the enrollee's income. The current sliding scale schedule to be used in determining applicable cost sharing responsibilities and out-of-pocket expenses is included in this Agreement as Attachment XI. The CONTRACTOR shall track and report to TENNCARE the amount of enrollee cost-sharing liabilities on a quarterly basis in a form and format to be specified by TENNCARE. TENNCARE shall aggregate cost-sharing information submitted by TennCare MCOs, BHOs and the PBM to identify enrollees that have met or exceeded their annual out-of-pocket expenditure maximum. The CONTRACTOR agrees to coordinate reimbursement to enrollees, either directly or through its network providers, that have exceeded the applicable out-of-pocket maximum, upon receipt of notification by TENNCARE. Should the CONTRACTOR elect to reimburse enrollees through its network providers, the CONTRACTOR shall conduct an audit of the providers that have been reimbursed in order to assure that enrollees received appropriate credit and/or reimbursement and are held harmless for amounts that exceed their out-of-pocket maximum.

The CONTRACTOR shall be expressly prohibited from waiving or using any alternative cost sharing schedules, unless required by TENNCARE. Further, the CONTRACTOR shall not discourage enrollees from paying applicable copayment obligations.

If, and at such time that TENNCARE amends the cost sharing rules, the rules shall automatically be incorporated into this Agreement and become binding on the CONTRACTOR and its providers.

Providers or collection agencies acting on the provider's behalf may not bill enrollees for amounts other than applicable cost sharing responsibilities for TennCare covered services except as permitted by TennCare rule 1200-13-12-.08 and as described below. Providers may seek payment from an enrollee in the following situations:

1. if the services are not covered by TennCare and the provider informed the enrollee the services were not covered prior to providing the service. The provider is required to inform the enrollee of the non-covered service and have the enrollee acknowledge the information. If the enrollee still requests the service, the provider shall obtain such acknowledgment in writing prior to rendering the service. Regardless of any understanding worked out between the provider and the enrollee about private payment, once the provider bills an MCO for the service that has been provided, the prior arrangement with the enrollee becomes null and void without regard to any prior arrangement worked out with the enrollee; or
2. if the enrollee's TennCare eligibility is pending at the time services are provided and if the provider informs the person they will not accept TennCare assignment whether or not eligibility is established retroactively. Regardless of any understanding worked out between the provider and the enrollee about private payment, once the provider bills an MCO for the service the prior arrangement with the enrollee becomes null and void without regard to any prior arrangement worked out with the enrollee; or

3. if the enrollee's TennCare eligibility is pending at the time services are provided, however, all monies collected, except applicable cost share amounts must be refunded when a claim is submitted to an MCO if the provider agreed to accept TennCare assignment once retroactive TennCare eligibility was established. (The monies collected shall be refunded as soon as a claim is submitted and shall not be held conditionally upon payment of the claim); or
4. the enrollee requests services that are non-TennCare covered services provided at the option of the CONTRACTOR in accordance with the terms of this Agreement.

The CONTRACTOR shall require, as a condition of payment, that the service provider accept the amount paid by the CONTRACTOR or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payor) plus any applicable amount of cost sharing responsibilities due from the enrollee as payment in full for the service. Should a provider, or a collection agency acting on the provider's behalf, bill an enrollee for amounts other than the applicable amount of cost sharing responsibilities due from the enrollee, once a CONTRACTOR becomes aware the CONTRACTOR shall notify the provider and demand that the provider and/or collection agency cease such action against the enrollee immediately. After notification by the CONTRACTOR, if a provider continues to bill an enrollee, the CONTRACTOR shall refer the provider to the TBI.

2-5 Services Not Covered

The CONTRACTOR shall not pay for non-covered services or for non-emergency services obtained out of plan unless ordered to do so by an administrative law judge, the State or the Health Services Team (as specified in Section 3). Non-covered services include, but are not limited to, the following:

- a. Any covered service that is not medically necessary, except that preventive and EPSDT services described in Section 2-3.1 and 2-3.3 of this Agreement shall be covered;
- b. Eyeglasses, hearing aids or non-emergency dental services for adults unless otherwise described in Section 2-3.1 and 2-3.3 of this Agreement;
- c. Services performed for cosmetic purposes;
- d. Medical services for individuals committed to penal institutions, whether local, state or federal;
- e. Medical services performed outside the United States;
- f. Organ transplants or other medical procedures which are considered experimental or investigational, including the performance of a specific medical procedure which would be covered except for the fact it is used in a manner that is not a recognized mode of treatment for a specific medical condition;
- g. Weight reduction programs; by-pass surgery (unless medically necessary), or gastric stapling (unless medically necessary);
- h. Services for the treatment of impotence or infertility or for the reversal of sterilization;
- i. Autopsy/Necropsy;
- j. Job-related illness or injury covered by workers compensation;
- k. Pre-employment physical examinations;
- l. Fitness to duty examinations;
- m. Drugs when prescribed for smoking cessation, hair growth, cosmetic purposes to beautify the skin, appetite suppression or weight reduction, treatment of impotence, or treatment of infertility; and

- n. Drugs which the Food and Drug Administration considers to be Less Than Effective (i.e., drugs for which a Notice Of Opportunity for Hearing has been published in the Federal Register) or identical, related or similar (IRS) drugs which are counterparts of Less Than Effective (LTE) drugs.

Any services to be excluded beyond those identified above shall require approval by TENNCARE.

2-6 Marketing and Enrollee Materials

2-6.1 Marketing

The CONTRACTOR may develop and implement a marketing plan and marketing materials for the purpose of providing general information to the public about TennCare Select. The CONTRACTOR's plan, materials and a description of all related activities must be submitted to TENNCARE for approval prior to implementation or use. All terms, conditions and policies stated herein apply to staff, agents, officers, subcontractors, providers, volunteers and anyone acting on behalf of the CONTRACTOR.

2-6.2 Enrollee Materials

The CONTRACTOR shall distribute various types of enrollee materials as required by this Agreement. These materials include, but may not be limited to member handbooks, provider directories, member newsletters, identification cards, fact sheets, notices, or any other material necessary to provide information to enrollees as described herein and in Section 4-1.2, etc. The CONTRACTOR may distribute additional materials and information, other than those required by this Section, to enrollees in order to promote health and/or educate enrollees. All materials sent to enrollees and enrollee communications including form letters, mass mailings and system generated letters, whether required or otherwise, shall require written approval by TENNCARE prior to dissemination as described herein and shall be designed and distributed in accordance with the minimum requirements as described in this Agreement. Letters sent to enrollees in response to an individual query do not require prior approval.

- a. The CONTRACTOR shall, in consultation with and following approval by the State, print and distribute all descriptive booklets, identification cards, letters, administrative forms and manuals pertaining to or to be sent to enrollees. Failure to have any enrollee materials approved, regardless of whether they are mentioned in the preceding sentence, by the State before release shall result in an assessment of \$500.00 per occurrence. The State shall immediately notify the CONTRACTOR of any such occurrence. Should TennCare not respond in the required amount of time, as set forth in Attachment I, the CONTRACTOR shall not be penalized as a result of implementing the item requiring approval. However, failure by TennCare to assess liquidated damages or penalties shall not preclude TennCare from requiring the CONTRACTOR to respond or modify the "item" if it is determined by TennCare to be in the best interest of the TennCare program.
- b. The cost of printing and distributing descriptive booklets, identification cards, and administrative forms and manuals shall be the responsibility of the CONTRACTOR.
- c. The CONTRACTOR is required to distribute the following enrollee materials:
 - 1. Member Handbooks. Member handbooks must be approved by TennCare prior to distribution. Member handbooks must be distributed to enrollees within thirty (30) days of enrollment in the CONTRACTOR's plan and shall, at a minimum, be in accordance with the following guidelines:
 - a. Must be in accordance with all applicable requirements as described in Section 2-6 of this Agreement;
 - b. Shall include a table of contents;

- c. Shall include an explanation on how members will be notified of member specific information such as effective date of enrollment;
- d. Shall include a description of services provided including limitations, exclusions, and out-of-plan use;
- e. Shall include a description of cost share responsibilities for non-Medicaid eligibles individuals including an explanation that providers and/or the MCO may utilize whatever legal actions that are available to collect these amounts;
- f. Shall include information about preventive services for adults and children (EPSDT) to include a listing of preventive services and notice that preventive services are at no cost and without cost share responsibilities;
- g. Shall include procedures for obtaining required services, including procedures for obtaining referrals to specialists as well as procedures for obtaining referrals to providers outside of the plan. The handbook should advise members that if they need a service that is not available within the plan, they will be referred to a provider outside of the plan and any co-payment requirements would be the same as if this provider were in the plan;
- h. Shall include an explanation of emergency services and procedures on how to obtain emergency services both in and out of the CONTRACTOR's service area;
- i. Shall include information on how to access the primary care provider on a 24-hour basis. The handbook may encourage members to contact this 24-hour service when they have questions as to whether they should go to the emergency room;
- j. Shall include appeal procedures as described in Section 2-8 of this Agreement;
- k. Shall include notice to the enrollee that in addition to the enrollee's right to file an appeal for actions taken by the CONTRACTOR, the enrollee shall have the right to request reassessment of eligibility related decisions directly to TENNCARE;
- l. Shall include written policies on member rights and responsibilities, pursuant to Quality Standard X of Attachment II of this Agreement;
- m. Shall include written information concerning advance directives as described in the Code of Federal Regulations, 42 CFR 489 Subpart I and in accordance with 42 CFR 417.436.(d);
- n. Shall include notice to the enrollee that enrollment in the CONTRACTOR's plan invalidates any prior authorization for services granted by another plan but not utilized by the enrollee prior to the enrollee's enrollment into the CONTRACTOR's plan and notice of continuation of care when entering the CONTRACTOR's plan as described in Section 2-7.1;
- o. Shall include notice to the enrollee that it is the member's responsibility to notify the CONTRACTOR and the TENNCARE agency each and every time the member moves to a new address;
- p. Shall include notice to the enrollee that a new enrollee may request to change MCO plans at anytime during the ninety (90) day period immediately following their initial enrollment in a MCO plan, subject to the capacity of the selected MCO to accept additional enrollees and any restrictions limiting enrollment levels established by TENNCARE. This process will require the enrollee to notify the State in a form that will be prescribed by the State;
- q. Shall include notice to the enrollee that the enrollee may change plans, unless otherwise specified by TennCare, during the next choice period as described in Section 4 of this

Agreement and shall have a ninety (90) day period immediately following the enrollment, as requested during said choice period, in a new plan to request to change plans, subject to the capacity of the selected MCO to accept additional enrollees and any restrictions limiting enrollment levels established by TENNCARE;

- r. Shall include notice to enrollee of their right to disenroll from the TennCare program at any time with instructions to contact TENNCARE for disenrollment forms and additional information on disenrollment;
- s. Shall include the toll free telephone number for TENNCARE with a statement that the enrollee may contact the plan or TENNCARE regarding questions about TennCare. The TennCare hotline number is 1-800-669-1851; and
- t. Shall include information on how to obtain information in alternative formats or how to access interpretation services.

There are certain selected requirements of those described above which need to be provided uniformly in all handbooks so that members have a clear understanding of benefits covered, exclusions, cost sharing responsibilities, members responsibilities to respond to requests for information (re: address, employment, third party liability, etc.), emergency services, appeal processes, appeal rights, rights to change plans and to disenroll from TennCare, and acceptable reasons for disenrollment. The CONTRACTOR shall use specific language provided by TENNCARE to describe these requirements.

- 2. Quarterly Newsletter. The CONTRACTOR shall, at a minimum, distribute on a quarterly basis a newsletter to all enrollees which is intended to educate the enrollee to the managed care system, proper utilization of services, etc., and encourage utilization of preventive care services. The CONTRACTOR shall include, in the newsletter; specific articles or other specific information as described and requested by TENNCARE. Such requests by TENNCARE shall be limited to two hundred (200) words and shall be reasonable including sufficient notification of information to be included. Not more than one hundred twenty (120) calendar days shall elapse between dissemination of this information. In addition to the prior authorization requirement regarding dissemination of materials to enrollees, the CONTRACTOR shall also submit to TENNCARE, ten (10) final copies of the newsletter and the date that the information was mailed to enrollees.
- 3. Identification Cards. The CONTRACTOR shall provide enrollees with identification cards. The cost of these items shall be borne by the CONTRACTOR. The State shall review and approve identification cards prior to issuance for use. Each enrollee shall be provided an identification card, which identifies the enrollee as a participant in the TennCare Program within thirty (30) calendar days of notification of enrollment into the CONTRACTOR's plan. The identification card must comply with all state and federal requirements, including but not limited to, the Standardized Pharmacy Benefit Identification Card Act. The identification card may be issued by the CONTRACTOR, subject to prior approval of the format and content by TENNCARE.

2-6.3 Permissible Marketing and/or Communication Activities

The following marketing activities shall be permitted under this contract pending approval of a marketing plan describing the time(s), place(s), intent, audience and other relevant information requested by TennCare.

- 1. Distribution of general information through mass media; and
- 2. Telephone calls, mailings and home visits to current enrollees of the CONTRACTOR only for the sole purpose of educating current enrollees about services offered by or available through the CONTRACTOR.
- 3. General activities that benefit the entire community (e.g., health fairs, school activity sponsorships, and health education programs)

2-6.4 Prohibited Marketing and/or Communication Activities

The following information and activities are prohibited:

1. Materials and/or activities that mislead, confuse or defraud or that are unfair or deceptive practices or that otherwise violate federal or state consumer protection laws or regulations. This includes materials which mislead or falsely describe covered or available services, membership or availability of network providers, and qualifications and skills of network providers;
2. Overly aggressive solicitation, such as repeated telephoning or continued recruitment after an offer for enrollment is declined by an enrollee, or similar techniques;
3. Gifts and offers of material or financial gain as incentives to enroll;
4. Compensation arrangements with marketing personnel that utilize any type of payment structure in which compensation is tied to the number of persons enrolled;
5. Direct solicitation of prospective enrollees;
6. In accordance with federal requirements, independent marketing agents shall not be used in connection with marketing activities. Independent marketing agents shall not mean staff necessary to develop or produce marketing materials or advertising or other similar functions

2-6.5 Prior Approval

- a. The CONTRACTOR shall submit a detailed description of its marketing plan, any materials it intends to use and a description of any marketing activities to be held prior to implementation or use. This includes but is not limited to all policies and manuals, advertisement copy, brochures, posters, fact sheets, video tapes, story boards for the production of videos, audio tapes, newsletters, any and all other forms of advertising as well as any other forms of public contact such as participation in health fairs and/or telemarketing scripts.
- b. All materials submitted by the CONTRACTOR shall be accompanied by a plan that describes the CONTRACTOR's intent and procedure for the use of the materials. All written material submitted by the CONTRACTOR must be submitted on paper and electronic file media. Materials developed by a recognized entity having no association with the CONTRACTOR that are related to management of specific types of diseases (e.g., heart, diabetes, asthma, etc.) or general health improvement must be submitted for approval; however, an electronic file for these materials may not be required. The electronic files, when required, must be submitted in a format acceptable to TENNCARE. Electronic files submitted in any other format than those approved by TENNCARE cannot be processed.
- c. TENNCARE shall review the Contractor's marketing plan, marketing activity descriptions and materials and either approve, deny or return the plan and/or materials (with written comments) within fifteen (15) calendar days from the date of submission.
- d. Once materials have been approved by TennCare, the CONTRACTOR shall submit ten (10) copies of the final product to the TennCare Marketing Coordinator.
- e. Marketing problems may not be evident from the materials submitted, but may become apparent upon use. TennCare reserves the right to notify the CONTRACTOR to discontinue or modify marketing plans, activities or materials after approval.
- f. Prior to modifying any approved marketing plan, marketing activity or material, the CONTRACTOR shall submit for approval by TennCare a detailed description of the proposed modification.

2-6.6 Written Material Guidelines

All written enrollee materials shall comply with the following requirements:

1. All materials shall be worded at a 6th grade reading level, unless TENNCARE approves otherwise.
2. All written materials shall be clearly legible with a minimum font size of 12pt. with the exception of member I.D. cards, and unless otherwise approved by TennCare.
3. All written materials shall be printed with an assurance of non-discrimination.
4. The following shall not be used on marketing or communication material without the written approval of TENNCARE:
 - a. The Seal of the State of Tennessee;
 - b. The TennCaresm name unless the initials "SM" denoting a service mark, is superscripted to the right of the name;
 - c. The word "free" can only be used if the service is no cost to all members. Only members who meet Medicaid eligibility requirements and those uninsured or uninsurable persons, as provided in the TennCare rules and regulations, are exempt from cost sharing responsibilities. If members have cost share responsibilities, the service is not free. Any conditions of payments must be clearly and conspicuously disclosed in close proximity to the "free" good or service offer.
 - d. The use of phrases to encourage enrollment such as "keep your doctor" implying that potential members can keep all of their physicians. Potential members in TennCare should not be led to think that they can continue to go to their current physician, unless that particular physician is part of that provider network. In order for the service to be paid for by TennCare, members may continue to see their physician only if the physician is participating in the same plan or if the plan approves care by the physician as an out-of-plan provider.
5. All vital MCO documents and the member handbook must be translated and available in Spanish.

Within ninety (90) days of notification from TENNCARE, all vital MCO documents must be translated and available to each Limited English Proficiency group identified by TENNCARE that constitutes five percent (5%) of the TennCare population or 1,000 enrollees, whichever is less.
7. All written materials shall be made available in alternative formats for persons with special needs or appropriate interpretation services shall be provided by the CONTRACTOR.
8. The CONTRACTOR shall provide written notice of any changes in policies or procedures described in written materials previously sent to enrollees. The CONTRACTOR shall provide written notice at least thirty (30) days before the effective date of the change.

2-6.7 Failure to Comply with Marketing and Enrollee Material Requirements

All services listed in marketing and enrollee materials must be provided as described and the materials must adhere to the requirements as described in this Agreement. Failure to comply with the marketing and communication limitations contained in this Agreement, including but not limited to the use of unapproved and/or disapproved marketing and communication material, may result in the imposition by TENNCARE of one or more of the following sanctions which shall remain in effect until such time as the deficiency is corrected:

- a. Revocation of previously authorized marketing methods;
- b. Refusal of TENNCARE to authorize new enrollments for a period specified by TENNCARE;

- c. Forfeiture by the CONTRACTOR of all or part of the administrative payments for persons enrolled as a result of non-compliant marketing practices; and/or
- d. Application of sanctions as provided in Section 6-8 of this Agreement.

2-7 Medical Management

The Contractor shall provide the State with two (2) written copies outlining its medical management procedures. Additionally, the Contractor shall obtain approval from the state, in writing, prior to implementing any changes, revisions, additions and/or deletions in these procedures.

2-7.1 Utilization Management

The CONTRACTOR shall not place arbitrary maximum limits on the length of stay for enrollees requiring hospitalization and/or surgery. The CONTRACTOR shall not employ, and shall not permit others acting on their behalf to employ utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each TennCare enrollee and his/her medical history. Individual patient characteristics must be considered in the determination of readiness for discharge. This requirement is not intended to limit the ability of the CONTRACTOR to place "tentative" limits on the length of a prior authorization or pre-certification.

- a. Inpatient Care. The Contractor shall provide for methods of assuring the appropriateness of inpatient care. Such methodologies shall be based on individualized determinations of medical necessity and, at a minimum, shall include:
 - i. pre-admission certification upon notification for all non-emergency admissions;
 - ii. a concurrent review program to monitor and review continued inpatient hospitalization (for hospitals that are not reimbursed on a DRG basis), length of stay (for hospitals that are not reimbursed on a DRG basis), outpatient care, or diagnostic ancillary services regarding their appropriateness and medical necessity. In addition, the Contractor shall have a process in place to determine for emergency admissions, based upon medical criteria, if and when a patient can be transferred to a network facility, if presently in a non-network facility. On-site concurrent hospitalization review should occur in 95% of the cases where applicable at the two most frequently utilized hospitals;
 - iii. admission review for urgent and/or emergency admissions, on a retroactive basis when necessary, in order to determine if the admission is medically necessary, and if the requested length of stay for the admission (for hospitals that are not reimbursed on a DRG basis and for outlier DRG cases) is reasonable based upon an individualized determination of medical necessity. Such reviews shall not result in delays in the provision of medically necessary urgent or emergency care;
 - iv. Pre-admission certification should not be employed for admissions for the normal delivery of children;
 - v. Prospective review procedures may also include pre-admission testing criteria and criteria for same day surgery procedures. If inpatient hospital pre-admission certification is utilized authorization or denial must occur within one business day of the request.
- b. Case Management. The Contractor shall maintain a case management program for enrollees. Enrollee participation is voluntary. The CONTRACTOR must utilize procedures and criteria that identify unique or complex cases that will benefit from intensive medical case management.
- c. Discharge Planning. The Contractor shall maintain and operate a formalized discharge planning program. The CONTRACTOR may delegate responsibility for discharge planning in accordance with requirements for the delegation of responsibilities specified in Attachment II.

- d. Disease Management. The Contractor must have in place or develop and implement a disease management and health promotion and prevention program. The Contractor shall develop and implement one disease management program for a high cost, high prevalence disease, designed to optimize the health status of members. The program shall include a statistically valid methodology designed to measure the impact on health status of participating members, and the Contractor shall provide the State with the results of the analysis of the program's impact at least 14 months after implementation. The State reserves the right to review and comment on the programs.
- e. Hospitalizations and Surgeries. The CONTRACTOR must comply with any applicable laws or rules related to length of hospital stay. TENNCARE will closely monitor encounter data related to length of stay and re-admissions to identify potential problems. If indicated, TENNCARE or the EQRO may conduct special studies to assess the appropriateness of hospital discharges.
- f. Prior Authorization
 - 1. General Rule. If prior authorization of a service is granted by the CONTRACTOR, subcontractor or an agent, payment for the pre-approved service shall not be denied based on the lack of medical necessity, assuming that the enrollee is eligible on the date of service, unless it is determined that the facts at the time of the denial of payment are significantly different than the circumstances which were described at the time that prior authorization was granted. Prior Authorization shall not be required for emergency services.
 - 2. At time of Enrollment. In the event an enrollee entering the MCO's plan is receiving medically necessary TennCare covered services the day before enrollment, the CONTRACTOR shall continue to make payment, without any form of prior approval and without regard to whether such services are being provided within or outside the CONTRACTOR's provider network until such time as the CONTRACTOR can reasonably transfer the enrollee to a service and/or network provider without impeding service delivery that might be harmful to the enrollee's health. If it is medically necessary that care extend beyond thirty (30) days, the CONTRACTOR shall require prior authorization for continuation of the services beyond thirty (30) days. Care rendered to an enrollee in the Contractor's plan beyond thirty (30) days that is out-of-plan or out-of-network for which a provider has not sought prior authorization shall not be reimbursed.
 - 3. Prenatal Care. In the event an enrollee entering the CONTRACTOR's plan is receiving medically necessary prenatal care services the day before enrollment, the CONTRACTOR shall continue to make payment for such medically necessary services, without any form of prior approval and without regard to whether such services are being provided within or outside the CONTRACTOR's provider network until such time as the CONTRACTOR can reasonably transfer the enrollee to a service and/or network provider without impeding service delivery that might be harmful to the enrollee's health. The CONTRACTOR shall require, as a condition of payment, that the service provider accept the amount paid by the CONTRACTOR or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payor) plus any applicable amount of cost sharing responsibilities due from the enrollee as payment in full for the service.

2-7.2 Pharmacy Management

- a. The CONTRACTOR shall implement an ongoing program which reviews the utilization of services, patterns of prescribing, and actual dispensing of drugs under the program and communicate the findings to the State and network providers semi-annually.
- b. The CONTRACTOR shall provide quarterly reports to the State regarding the specific cost and utilization of prescription drugs under the program.

2-8 Complaints and Appeals

All enrollees shall be afforded the right to file a complaint and/or appeal. The CONTRACTOR shall refer all enrollees who are dissatisfied with the CONTRACTOR's initial response to the complaint/appeal coordinator for the appropriate action.

The enrollees shall have the right to file appeals regarding adverse actions taken by the CONTRACTOR. For purposes of this requirement, appeal shall mean an enrollee's right to contest verbally or in writing, any adverse action taken by the CONTRACTOR to deny, reduce, terminate, delay or suspend a covered service as well as any other acts or omissions of the CONTRACTOR which impair the quality, timeliness, or availability of such benefits. Complaint shall mean an enrollee's right to contest any other action taken by the CONTRACTOR or service provider other than those that meet the definition of an adverse action. The CONTRACTOR shall provide readable materials reviewed and approved by TENNCARE, informing enrollees of their complaint and appeal rights. The CONTRACTOR has internal complaint and appeal procedures in accordance with TennCare rule 1200-13-12-.11 or any applicable TennCare rules, subsequent amendments, or subsequent Court Orders governing the appeals process.

A portion of the regularly scheduled Quality Improvement meetings, as described in Section 2-9.6 shall be devoted to the review of enrollee complaints and appeals that have been received and resolved. The complaint and appeal procedures shall be governed by the following guidelines which are in accordance with TennCare policy as specified in TennCare rules and regulations and any and all Court Orders.

2-8.1 Appeals

The CONTRACTOR's appeal process shall be submitted for review and approval and shall include, at a minimum, the following:

1. The CONTRACTOR shall have a contact person appointed at each service site. Said person will be knowledgeable of appeal procedures and direct all appeals whether the appeal is verbal or the enrollee chooses to file in writing. Should an enrollee choose to appeal in writing, the enrollee will be instructed to file via mail to the designated P. O. Box for appeals related to the CONTRACTOR;
2. There shall be sufficient support staff (clerical and professional) available to process appeals in accordance with TennCare requirements related to the appeal of Adverse Actions Affecting a TennCare Program Enrollee. Staff shall be knowledgeable about applicable state and federal law and all court orders governing appeal procedures, as they become effective. This shall include, but not be limited to, appointed staff members and phone numbers identified to TENNCARE where appropriate staff may be reached;
3. Staff shall be educated concerning the importance of the procedure and the rights of the enrollee and the timeframes in which action must be taken by the CONTRACTOR regarding the handling and disposition of an appeal;
4. The appropriate individual or body within the plan having decision-making authority as part of the appeal procedure shall be identified;
5. The CONTRACTOR shall have the ability to take telephone appeals and accommodate persons with disabilities during the appeals process. Furthermore, appeal forms shall be available at each service site and by contacting the CONTRACTOR. However, enrollees shall not be required to use an appeal form in order to file an appeal;
6. Upon request, the enrollee shall be provided a TENNCARE approved appeal form(s);
7. All appellants shall have the right to reasonable assistance by the CONTRACTOR during the appeal process;

8. Reports of appeals shall be submitted quarterly to TENNCARE and shall include recommendations to, and actions taken by QI Committee, in such format and manner determined by TENNCARE;
9. At any point in the appeal process, TENNCARE shall have the authority to remove an enrollee from the CONTRACTOR's plan when it is determined that such removal is in the best interest of the enrollee and TENNCARE; and
10. TENNCARE may develop additional appeal process guidelines or rules, including requirements as to content and timing of notices to enrollees, which shall be followed by the CONTRACTOR, if TENNCARE determines that it is in the best interest of the TennCare Program or if necessary to comply with federal or judicial requirements. However, CONTRACTOR shall not be precluded from challenging any judicial requirements and to the extent judicial requirements that are the basis of such additional guidelines or rules are stayed, reversed or otherwise rendered inapplicable, CONTRACTOR shall not be required to comply with such guidelines or rules during any period of such inapplicability.

2-8.2 Complaints

The enrollee has the right to file complaints. Complaint shall mean an enrollee's right to contest any other action taken by the CONTRACTOR or service provider other than; the denial, reduction, termination, delay or suspension of a covered service, as well as any other acts or omissions of the CONTRACTOR which impair the quality, timeliness, or availability of such benefits.

1. The CONTRACTOR shall have a contact person appointed at each service site. Said person will direct all complaints to the complaint coordinator at CONTRACTOR's corporate office;
2. There shall be sufficient support staff (clerical and professional) available to process complaints;
3. Staff shall be educated concerning the importance of the procedure and the rights of the enrollee;
4. The appropriate individual or body within the plan having decision making authority as part of the complaint procedure shall be identified;
5. Complaint forms shall be available at each service site and by contacting the CONTRACTOR;
6. All persons filing complaints shall have the right to reasonable assistance by the CONTRACTOR during the CONTRACTOR's complaint process;
7. Complaints shall be resolved within thirty (30) calendar days from the initial filing of the complaint document by the enrollee. The decision of the MCO shall be in writing and include a description of the complaint, the basis for the decision and identification of any documents reviewed and relied upon in the complaint decision;
8. At any point in the complaint process, TENNCARE shall have the authority to intercede in the process when it is determined that such intervention is in the best interests of the enrollee and TennCare.

If it is determined by TENNCARE that violations regarding the appeal guidelines have occurred by the CONTRACTOR, TENNCARE shall require that the CONTRACTOR submit and follow through with a corrective action plan. Failure to comply with the appeal guidelines issued by TENNCARE, including an acceptable corrective action plan, shall result in the CONTRACTOR being subject to liquidated damages as described in Section 6-8.2 of this Agreement.

2-9 Administration And Management

2-9.1 General

- a. The State may review and approve all plan policies developed by the CONTRACTOR related to administration of TennCare Select. On an ongoing basis, should the CONTRACTOR have a question on policy determinations, benefits or operating guidelines, the CONTRACTOR shall request a determination in writing. The State shall have 30 days to respond unless specified otherwise. Should TennCare not respond in the required amount of time, the CONTRACTOR shall not be penalized as a result of implementing items awaiting approval. However, failure to respond timely shall not preclude the State from requiring the CONTRACTOR to respond or modify the policy or operating guideline prospectively. The CONTRACTOR shall be afforded at least 60 days to implement the modification.
- b. The CONTRACTOR shall meet with representatives of the State on a monthly basis during the first three months of this contract and quarterly thereafter to discuss any problems and/or progress on matters outlined by the State. The CONTRACTOR shall have in attendance its Program Director, and representatives from its organizational units required to respond to topics identified by the State or the CONTRACTOR. The CONTRACTOR shall provide information concerning its efforts on network development, provider training, attempts to locate non-responsive TennCare eligibles and trends in costs and utilization. The CONTRACTOR shall develop a quarterly report package that includes at a minimum the reports identified in Section 2-10.11 of this Agreement.
- c. The following performance indicators related to administration and management have been identified for ongoing monitoring. The CONTRACTOR's failure to meet these benchmarks or demonstrate improvement toward benchmark levels of performance shall result in the CONTRACTOR being required to implement a corrective action plan as described in Section 2-16.

Performance Indicator	Data Sources	Measure	Target	Benchmark
Volume of Provider Complaints	Weekly Activity Report	# of provider complaints received relative to number of providers (Complaint is defined as an issue a provider presents to the managed care organization, either in written or oral form, which is subject to resolution by the MCO).	0 percent	MCO specific benchmark. 10% reduction over prior year.
Claims Payment Accuracy	Weekly Activity Report	# of claims paid accurately upon initial submission	100 percent	97% accuracy upon initial submission
Approximate Waiting Time for Provider Response	Weekly Activity Report	Average response time on provider services line	Average response time of 30 seconds	Average response time of 60 seconds

Performance Indicator	Data Sources	Measure	Target	Benchmark
Abandonment rate for Member Services lines	Weekly Activity Report	Percent of calls not answered; callers hang up while in queue	0 percent	Less than 5 percent of calls not answered
Approximate Waiting Time for Member Response	Weekly Activity Report	Average Response Time on Member Services Line	Average response time of 30 seconds	Average response time of 60 seconds
Specialist Provider Network	Monthly Provider listing	Executed Contract Agreements	Same as benchmark	Executed specialty physician contracts in all priority areas designated by the state located within the MCO's Grand Region for the following nine specialists: cardiology; gastroenterology; neurology; neurosurgery; otolaryngology; ophthalmology; orthopedics; oncology/hematology; and urology.

2-9.2 Staff Requirements

- a. The CONTRACTOR shall not have an employment, consulting, or any other agreement with a person that has been debarred or suspended by any federal agency for the provision of items or services that are significant and material to the entity's contractual obligation with the State.
- b. The staffing for the plan covered by this Agreement must be capable of fulfilling the requirements of this Agreement. The minimum staff requirements are as follows:
 1. A full-time administrator (project director) specifically identified with overall responsibility for the administration of this Agreement. This person shall be at the CONTRACTOR's officer level. Said designee shall be responsible for the coordination and operation of all aspects of the Agreement;
 2. Sufficient full-time support staff to conduct daily business in an orderly manner; including such functions as administration, accounting and finance, prior authorizations, marketing, appeal system resolution, and claims processing and reporting, as determined through management and medical reviews;
 3. A physician who is licensed in the State of Tennessee to serve as medical director to oversee and be responsible for the proper provision of covered services to members;
 4. A staff qualified, medically trained personnel, consistent with accreditation standards of NCQA, JCAHO or URAC whose primary duties are to assist in evaluating claims for medical necessity;
 5. A person who is trained and experienced in information systems, data processing and data reporting as required to provide necessary and timely reports to TENNCARE;

6. The CONTRACTOR shall appoint a staff person to be responsible for Title VI compliance on behalf of the CONTRACTOR. The CONTRACTOR does not have to require that Title VI compliance be the sole function of the designated staff member. However, the CONTRACTOR shall identify the designated Title VI compliance staff member to TENNCARE by name. At such time that this function is redirected, the name of the staff member who assumed the duties shall be reported in writing to TENNCARE within ten (10) calendar days of the change;
7. The CONTRACTOR shall appoint a staff person to be responsible for communicating with TENNCARE regarding member service issues. The CONTRACTOR shall maintain statewide, toll-free phone lines (member services hotline) for the exclusive purpose of enrollee inquiries. These phone lines shall be staffed adequately to respond to enrollee's questions during normal business hours, five (5) days a week. The member service lines shall be adequately staffed and trained to accurately respond to questions regarding the TennCare program, including but not limited to EPSDT. Said information may be made available pursuant to the CONTRACTOR's enrollee newsletter or materials distributed pursuant to Section 2-6 of this Agreement. The CONTRACTOR shall adequately staff the member service line to assure that the average wait time for assistance does not exceed 10 minutes;
8. The CONTRACTOR shall appoint a staff person to be responsible for communicating with TENNCARE regarding provider service issues. Further, the CONTRACTOR shall have a provider service line staffed adequately to respond to providers questions during normal business hours, including appropriate and timely responses regarding prior authorization requests as described in Section 2-7.1 of this Agreement. The provider service lines shall be adequately staffed and trained to accurately respond to questions regarding the TennCare program, including but not limited to EPSDT. The CONTRACTOR shall adequately staff the provider service line to assure that the average wait time for assistance does not exceed 10 minutes.
9. The CONTRACTOR shall identify in writing key contact persons for Contract Administration, Accounting and Finance, Prior Authorizations, Marketing, Claims Processing, Information Systems, Title VI Compliance, Member Services, Provider Services, Appeal System Resolution, Medical Management, and EPSDT within thirty (30) days of Agreement execution. Any changes in staff persons during the term of this Agreement must be made in writing within 10 business days.
10. TENNCARE may establish Technical Advisory Groups (TAGs) as needed to address issues in key areas of the program. These TAGs will consist of key stakeholders including TENNCARE and MCO staff. Areas around which TAGs may be formed are: Third Party Liability and Coordination of Benefits, Fraud and Abuse, Quality Indicators, Financial Reporting and Claims Processing.

The CONTRACTOR's failure to comply with staffing requirements as described in this agreement shall result in the application of intermediate sanctions and liquidated damages as specified in Section 6 of this Agreement.

2-9.3 Licensure of Staff

The CONTRACTOR is responsible for assuring that all persons, whether they be employees, agents, subcontractors, providers or anyone acting for or on behalf of the CONTRACTOR, are legally authorized to render service under applicable state law and/or regulations. Failure to adhere to this provision shall result in assessment of \$250 per calendar day for each day that personnel are not licensed as required by applicable state law and/or regulation and TENNCARE may terminate this Agreement for cause as described in Section 6.2 of this Agreement.

1. TENNCARE may refuse to approve or may rescind the approval of subcontracts with unlicensed persons;
2. TENNCARE may refer the matter to the appropriate licensing authority for action;
3. TENNCARE may assess liquidated damages as described in Section 6 of this Agreement; and

4. TENNCARE may terminate this Agreement for cause as described in Section 6.2. of this Agreement.

The CONTRACTOR's failure to comply with licensure of staff requirements as described in this agreement shall result in the application of intermediate sanctions and liquidated damages as specified in Section 6 of this Agreement.

2-9.4 Network Management

- a. The CONTRACTOR shall notify all network providers to file claims associated with their services directly with the CONTRACTOR, or its subcontractors, on behalf of TennCare Select enrollees.
- b. The CONTRACTOR shall notify all network providers of and enforce compliance with all provisions relating to utilization management procedures.
- c. Provider Profiling. The CONTRACTOR shall profile TennCare Select providers and Best Practice Network Primary Care Providers. Provider profiling will include the following:
 1. Out-of-Network Utilization. The CONTRACTOR shall maintain a procedure to identify out-of-network utilization of enrollees by PCP panel (including BPN-PCPs), establish criteria for the evaluation of such instances and provide information to the state concerning the procedure, criteria and the results of any reviews and follow-up activities to correct referrals that are found to be "inappropriate" (e.g., consistent utilization of non-network providers when in-network providers available) on a quarterly basis.
 2. Specialist Referrals. The CONTRACTOR shall maintain a procedure to identify Specialty provider utilization of enrollees by PCP panel (including BPN-PCPs), establish criteria for evaluation for specialty utilization and provide information to the state concerning the procedure, criteria and the results of any reviews and follow-up activities to correct specialist utilization found to be inappropriate on a quarterly basis.
 3. Emergency Room Utilization. The CONTRACTOR shall maintain a procedure to identify enrollees who establish a pattern of accessing emergency room services, establish criteria for the evaluation of such instances, and notify the enrollee's PCP (including BPN-PCPs). The CONTRACTOR shall provide information to the state concerning the procedure, criteria and results of any reviews and follow-up activities on a quarterly basis.

2-9.5 Location of Non-responsive TennCare eligibles

The CONTRACTOR agrees to attempt to locate "non-responsive TennCare eligibles" that have been enrolled in the CONTRACTOR's plan. Non-responsive TennCare eligibles are persons identified by TennCare who have not responded to re-verification attempts and who have not (and whose family members have not) accessed services during the period of review. Within 90 days of identification, the CONTRACTOR shall attempt to reach each non-responsive TennCare eligible identified by TennCare to the CONTRACTOR and assigned to TennCare Select effective July 1, 2001. The CONTRACTOR shall attempt to reach each non-responsive TennCare eligible telephonically using the phone number provided by TennCare. Upon placement of the call, if the CONTRACTOR receives a message that the phone number has been changed, the CONTRACTOR shall update the enrollee's phone number in its system and make at least three documented attempts to contact said enrollee at the new number to obtain the enrollee's new address. If successful, the CONTRACTOR will forward this information to TennCare via the Weekly Enrollee Information Report. If TennCare does not provide a telephone number, the CONTRACTOR shall make and document at least one attempt to contact the non-responsive TennCare eligible through other publicly available information resources. In addition, the CONTRACTOR shall monitor claims activity for non-responsive TennCare eligibles. In the event the CONTRACTOR receives a claim for payment on behalf of a non-responsive TennCare eligible, the CONTRACTOR shall contact the provider and request the enrollee's phone number and address on file with the provider. The CONTRACTOR shall make at least three documented attempts to contact the enrollee at the location provided by the provider to confirm the enrollee's address. Once confirmed, the CONTRACTOR shall forward this information to TennCare via the Weekly Enrollee Information Report. The

CONTRACTOR shall complete this process within 45 days for other non-responsive TennCare eligible as they are identified by TennCare to the CONTRACTOR.

2-9.6 Quality Monitoring/Quality Improvement (QM/QI) Program

The CONTRACTOR shall have a Quality Monitoring/Quality Improvement (QM/QI) program. This program shall use as a guideline the Quality Monitoring Standards in Attachment II of this Agreement and shall be approved by TENNCARE prior to the enrollment of any TennCare enrollees. Any changes to the QM/QI program structure shall require prior written approval from TENNCARE. The QM/QI program shall be submitted to TENNCARE annually for reconsideration for approval along with the annual Quality Monitoring Program (QMP) review described in Standard II.D. in Attachment II of this Agreement.

2-9.6.1 QM/QI Meeting Requirements

The CONTRACTOR shall provide the Medical Director of TENNCARE with ten (10) days advance notice of all regularly scheduled meetings of the Quality Monitoring/Quality Improvement Committee and Peer Review Committee. The Medical Director of TENNCARE, or his/her designee, may attend the Quality Monitoring/Quality Improvement Committee and/or Peer Review Committee meetings at his/her option. In addition, written minutes shall be kept of all meetings of the Quality Monitoring/Quality Improvement Committee. A copy of the written minutes for each meeting shall be available on-file after the completion of the following committee meeting in which the minutes are approved and shall be available for review upon request and during the annual on-site EQRO review.

2-9.6.2 Performance Indicators

The CONTRACTOR shall demonstrate meaningful improvement towards achieving the benchmark level of performance for each performance indicator specified in Attachment II, Quality of Care Monitors. To be considered meaningful, the CONTRACTOR must demonstrate a 10-percentage point improvement over the baseline or satisfaction of the specified benchmark. For the period July 1, 2001 through December 31, 2001 the baseline is the average calendar year 2000 TennCare MCO performance level for the equivalent populations. For the period January 1, 2002 through December 31, 2002, the baseline will be defined as the higher of the Contractor's performance level for July 1, 2001 through December 31, 2002 or the average MCO performance level for calendar year 2000.

The CONTRACTOR may elect to participate in a workgroup facilitated by the TennCare Medical Director to finalize benchmarks and the methodology for calculating the performance indicators specified in Attachment II. With the exception of EPSDT, HEDIS Medicaid technical specifications shall be followed for the calculation of clinical performance indicators. The benchmark for EPSDT shall be an adjusted periodic screening percentage of greater than 80%. New or additional performance indicators may be added at the mutual agreement of TennCare and the CONTRACTOR. TennCare may modify the benchmarks on an annual basis to facilitate continuous improvement. The workgroup established above will participate in the specification of new benchmarks.

Performance indicator results shall be reported to TennCare within 90 days of the end of the calendar year. The CONTRACTOR shall develop and analyze performance indicators independently for SSI children (Group 2), children in state custody and transitioning out of State Custody (Groups 1.A and 1.B) and enrollees of the back-up population (Group 6). TennCare agrees to assist with the identification of Group 6 enrollees. The CONTRACTOR shall not be required to develop and analyze performance indicators for enrollees in Groups 3, 4, or 5 as defined in Section 4 of this Agreement.

The CONTRACTOR's failure to demonstrate meaningful improvement toward benchmark levels of performance shall result in the CONTRACTOR being required to implement a corrective action plan as described in Section 2-16.

2-9.6.3 *EPSDT*

The CONTRACTOR shall demonstrate at least a 10 percentage-point improvement over the average MCO fiscal year 2000 EPSDT adjusted periodic screening percentage (APSP) for SSI children and at least a 10 percentage-point improvement over the average fiscal year 2000 APSP EPSDT screening rate for all other children enrolled in TennCare Select.

To encourage significant improvement in EPSDT screening rates, the CONTRACTOR may recommend a program designed to increase screening rates through the use of financial incentives. TennCare must approve the program design and amount of any payments prior to distribution.

As specified at 2-4.9, the CONTRACTOR shall contract with each Department of Health for the provision of EPSDT services in the community service area(s) in which it is authorized to serve until such time as it obtains an APSP of eighty percent (80%).

2-9.6.4 *Credentialing Verification Organization*

The CONTRACTOR agrees to contract with the Credentialing Verification Organization (CVO) contracted by the State to verify credentials of all primary care provider and all other physicians (including specialists) that the MCO does not either credential itself for a commercial line of business or delegate responsibility of credentialing to a large provider group. The exemption to the requirement to utilize the CVO to verify credentials of a provider in cases where the MCO has credentialed the provider for a commercial line of business, shall only apply if an MCO's, or an MCO's parent company's, commercial line of business accounts for at least fifty (50) percent of its total book of business. Also for the purpose of this requirement a "large" provider group is a provider group with at least 100 providers unless otherwise specified by TENNCARE. The State shall negotiate a rate and establish a standard set of activities in its contract with the CVO. The CONTRACTOR shall have the right to obtain additional services from the CVO, however, nothing in this agreement requires the CONTRACTOR to contract with the CVO for the purpose of verifying credentials of providers who are not primary care providers or other physicians.

For the purpose of providers for whom the CVO is to verify credentials, Contractors in existence prior to July 1, 2000 shall not be required to re-credential primary care providers and other physicians previously credentialed until the expiration of the three (3) year term required by the Quality of Care Monitors (Attachment II). Upon expiration of the three (3) year term, the Contractors shall utilize the State-contracted CVO to provide information to be used for re-credentialing of all primary care providers and all other physicians as described above.

An MCO that has provided the State notice to terminate the TennCare program shall not be required to utilize the CVO to verify credentials of providers who were previously credentialed in accordance with applicable TennCare credentialing standards and requirements. Re-credentialing shall not be required until the expiration of the three (3) year term required by the Quality of Care Monitors (Attachment II). Upon expiration of the three (3) year term, Contractors shall utilize the State-contracted CVO to verify credentials of all primary care providers and all other physicians.

The CONTRACTOR shall establish policies and procedures to ensure adequate due process for any provider where the CONTRACTOR fails to contract with the provider based on information obtained from the CVO as to provider's credentials.

2-9.6.5 *Medical Records Requirements*

The CONTRACTOR shall maintain, when appropriate, and shall require contract providers to maintain up-to-date medical records at the site where medical services are provided for each member enrolled under this Agreement. The record shall include, at a minimum, medical charts, prescription orders, diagnoses for which medications were administered or prescribed, documentation of orders for laboratory, radiological, EKG, hearing, vision, and other tests and the results of such tests and other documentation sufficient to disclose the quality, quantity,

appropriateness, and timeliness of services performed or ordered under this Agreement. Each member's record must be legible and maintained in detail consistent with good medical and professional practice which permits effective internal and external peer review and/or medical audit and facilitates an adequate system of follow-up treatment.

2-9.7 Claims Processing

- a. Timeliness of Payment. The CONTRACTOR shall have in place, an automated claims processing system capable of accepting and processing claims submitted electronically with the exception of claims that require written documentation to justify payment (e.g., hysterectomy/sterilization consent forms, Certification for Medical Necessity for Abortion, necessary operative reports, etc.). To the extent that the CONTRACTOR compensates providers on a fee for service or other basis requiring the submission of claims as a condition to payment, the CONTRACTOR shall process, as described herein, the provider's claims for covered benefits provided to enrollees consistent with applicable CONTRACTOR policies and procedures and the terms of this Agreement. The CONTRACTOR shall ensure that ninety percent (90%) of claims for payment for services delivered to a TennCare enrollee (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) days of the receipt of such claims. The CONTRACTOR shall process, and if appropriate pay, within sixty (60) days ninety-nine point five percent (99.5%) of all provider claims for services delivered to an enrollee in the TennCare program. "Pay" means that the CONTRACTOR shall either send the provider cash or cash equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to the CONTRACTOR. "Process" means the CONTRACTOR must send the provider a written remittance advice or other appropriate written notice evidencing either that the claim has been paid or informing the provider that a claim has been either partially or totally "denied" and specify all known reasons for denial. If a claim is partially or totally denied on the basis the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written notice must specifically identify all such information and documentation. Resubmission of a claim with further information and/or documentation shall constitute a new claim for purposes of establishing the time frame for claims processing. If requested by the provider, the CONTRACTOR shall provide an electronic status report indicating the disposition for every adjudicated claim for each claim type submitted by providers seeking payment as well as payments generated and paid by the MCO. The status report shall contain appropriate explanatory remarks related to payment or denial of the claim.

To the extent that the provider agreement requires compensation of a provider on a monthly fixed fee basis or on any other basis that does not require the submission of a claim as a condition to payment, such payment shall be made to the provider by no later than (i) the time period specified in the contract between the provider and the CONTRACTOR or subcontractor, or if a time period is not specified in the contract (ii) the tenth (10th) day of the calendar month if the payment is to be made by a subcontractor, or (iii) if the CONTRACTOR is required to compensate the provider directly, within five (5) calendar days after receipt of the payment and supporting Remittance Advice information from TENNCARE.

The CONTRACTOR shall contract with independent reviewers for the purposes of said reviewers to review disputed claims as provided by T.C.A., Section 56-32-226.

- b. Electronic Billing. The CONTRACTOR shall provide the capability of electronic billing. The CONTRACTOR or any entities acting on behalf of the CONTRACTOR, shall not charge providers for filing claims electronically. However, this provision shall not be construed to imply that providers may not be responsible for payment of applicable line fees and/or charges. The CONTRACTOR shall comply at all times with standardized paper billing forms/format as follows:

<u>Claim Type</u>	<u>Claim Form</u>
Professional	HCFA 1500
Institutional	UB-92
Pharmacy	NCPDP (Edit Format)
Dental	ADA

- c. Standard Forms and Billing Instructions. The CONTRACTOR shall not revise or modify the standardized forms or format itself specified in item b. above. Further, the CONTRACTOR agrees to adopt national EMC standards and standardized instructions and definitions that are consistent with industry norms for the forms identified above when developed by TENNCARE in conjunction with appropriate workgroups.
- d. HIPAA Compliance. The CONTRACTOR agrees to maintain compliance with the Health Insurance Portability and Accountability Act (HIPAA). Further, the CONTRACTOR agrees that at such time that the Steering Committee presents TENNCARE with recommendations concerning claims billing and processing that are consistent with industry norms, the CONTRACTOR shall comply with said recommendations within one hundred and eighty (180) days from notice by TENNCARE to do so.
- e. The CONTRACTOR shall confirm eligibility on each participant as claims are submitted, on the basis of the eligibility information provided by the State or DCS (via the adhoc reporting process approved by TennCare) that applies to the period during which the charges were incurred. The CONTRACTOR shall process said claims, in an accurate manner in accordance with this Agreement.
- f. The CONTRACTOR shall aggressively pursue all third party liability recovery opportunities and shall make a concerted effort to produce third party liability recoveries of at least three percent (3%) of claims paid per fiscal year for Medicaid eligibles and of at least four percent (4%) of claims paid per fiscal year for Disabled eligibles.
- g. The CONTRACTOR shall perform front end system edits for medical necessity and conduct post-payment review on a sample of claims to ensure services provided were medically necessary. The CONTRACTOR must have a staff qualified, medically trained personnel, consistent with accreditation standards of NCQA, JCAHO or URAC whose primary duties are to assist in evaluating claims for medical necessity.
- h. The CONTRACTOR shall use its best efforts to recover overpayment of benefits that result from errors of the Contractor. Should the CONTRACTOR inadvertently make payment, arising from errors in overpayment, the amount of overpayment actually recovered should be credited to the State within forty-five (45) days after recovery of the overpaid funds by the CONTRACTOR. In the event any overpayment is not recovered within 90 days of discovery of the overpayment – and if the State has already made payment of the claims that included the overpayment – the CONTRACTOR will credit the State for the amount of the overpayment.
- i. Overpayments due to provider billing errors and provider fraud or fraud of any other type, other than fraud by employees or contractors of the CONTRACTOR, will not be considered overpayments due to errors of the Contractor. In addition, the State will not hold the Contractor responsible for overpayment caused by the State's omission or errors in certifying eligibility; however, the Contractor is required to assist in recovery of overpayments due to provider billing errors or due to State errors or omissions.
- j. Failure to meet claims processing requirements shall result in the application of liquidated damages in the amount of \$10,000 per month for each month the CONTRACTOR is out of compliance.

2-9.8 Third Party Recoveries

The CONTRACTOR shall be the payer of last resort for all medical services. The CONTRACTOR shall exercise, full assigned benefit rights and/or subrogation rights as applicable and shall be responsible for making every reasonable effort to determine the legal liability of third parties to pay for services rendered to enrollees under this Agreement and recover any such liability from the third party. Further, in accordance with Section 2-10.2, the CONTRACTOR shall report to TENNCARE any information regarding an enrollee's third party resources.

- a. If the CONTRACTOR has determined that third party liability exists for part or all of the services administered directly by the CONTRACTOR, the CONTRACTOR shall make reasonable efforts to recover from third party liable sources the value of services rendered. The CONTRACTOR shall make all reasonable efforts to produce third party recoveries of at least three percent (3%) of claims paid per fiscal year for Medicaid eligibles and at least four percent (4%) of claims paid per fiscal year for Disabled eligibles.

- b. If the CONTRACTOR has determined that third party liability exists for part or all of the services provided to an enrollee by a provider, the CONTRACTOR shall pay the provider only the amount, if any, by which the provider's allowable claim exceeds the amount of third party liability.
- c. The CONTRACTOR may not withhold payment for services provided to a member if third party liability or the amount of liability cannot be determined, or payment will not be available within a reasonable time.
- d. All funds recovered from third parties will be treated as offsets to claims payments.
- e. Cost sharing responsibilities permitted pursuant to Section 2-4.10 of this Agreement shall not be considered third party resources for purposes of this requirement.
- f. The CONTRACTOR shall provide third party resource (TPR) data to any provider having a claim denied by the CONTRACTOR based upon a TPR.
- g. The CONTRACTOR shall provide any information necessary to assist and shall cooperate in any manner necessary, as requested by TENNCARE, with a Cost Recovery Vendor at such time that TENNCARE acquires said services.

2-9.9 Fraud and Abuse Prevention and Detection

Pursuant to Executive Order 47, the Tennessee Bureau of Investigation Medicaid Fraud Control Unit (TBI MFCU) is the state agency responsible for the investigation of provider fraud and abuse in the State Medicaid program (TennCare).

Program Integrity is responsible for assisting TBI MFCU with provider cases and has the primary responsibility to investigate TennCare enrollee fraud and abuse.

All managed care organizations shall immediately report to the TBI MFCU any suspicious activity that has some factual basis or knowledge of provider fraud and/or abuse, including but not limited to the false or fraudulent filings of claims and/or the acceptance or failure to return monies allowed or paid on claims known to be false or fraudulent. The reporting entity shall not attempt to investigate or resolve the reported suspicion, knowledge or action without informing the TBI MFCU and must cooperate fully in any investigation by the TBI MFCU or subsequent legal action that may result from such an investigation. TennCare managed care organizations and health care providers shall, upon request, make available to the TBI MFCU any and all administrative, financial and medical records relating to the delivery of items or services for which TennCare monies are expended. In addition, the TBI MFCU must be allowed access to the place of business and to all TennCare records of any TennCare managed care organization or health care provider during normal business hours, except under special circumstances when after hour admission shall be allowed. Special circumstances shall be determined by the TBI MFCU.

All managed care organizations shall report TennCare enrollee fraud and abuse to Program Integrity. The reporting entity may be asked to help and assist in the investigations by providing requested information and access to records. TennCare managed care organizations and health care providers shall, upon request, make available any and all supporting documentation /records relating to delivery of items or services for which TennCare monies are expended. Shall the need arise, Program Integrity must be allowed access to the place of business and to all TennCare records of any TennCare managed care organizations or health care provider during normal business hours.

- a. The CONTRACTOR shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities. The CONTRACTOR shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the CONTRACTOR in preventing and detecting potential fraud and abuse activities.
- b. The CONTRACTOR shall have a written Fraud and Abuse compliance plan. The CONTRACTOR's specific internal controls and polices and procedures shall be described in a comprehensive written plan and be maintained on file with the CONTRACTOR for review and approval by TENNCARE and the Program

Integrity Unit within 90 days of the effective date of this Agreement. TennCare and the Program Integrity Unit shall provide notice of approval, denial, or modification to the CONTRACTOR within 30 days of review. The CONTRACTOR shall make any requested updates or modifications available for review after modifications are completed as requested by TENNCARE and/or the Program Integrity Unit within 30 days of a request. At a minimum the written plan shall:

1. Ensure that all officers, directors, managers and employees know and understand the provisions of the CONTRACTOR's fraud and abuse compliance plan;
 2. Contain procedures designed to prevent and detect potential or suspected abuse and fraud in the administration and delivery of services under this contract;
 3. Include a description of the specific controls in place for prevention and detection of potential or suspected abuse and fraud, such as:
 - a. Claims edits;
 - b. Post-processing review of claims;
 - c. Provider profiling and credentialing;
 - d. Prior authorization;
 - e. Utilization management;
 - f. Relevant subcontractor and provider agreement provisions;
 - g. Written provider and enrollee material regarding fraud and abuse referrals.
 4. Contain provisions for the confidential reporting of plan violations to the designated person as described in item 3 below;
 5. Contain provisions for the investigation and follow-up of any compliance plan reports;
 6. Ensure that the identities of individuals reporting violations of the plan are protected;
 7. Contain specific and detailed internal procedures for officers, directors, managers and employees for detecting, reporting, and investigating fraud and abuse compliance plan violations;
 8. Require any confirmed or suspected provider fraud and abuse under state or federal law be reported to TBI MFCU and that enrollee fraud and abuse be reported to Program Integrity;
 9. Ensure that no individual who reports plan violations or suspected fraud and abuse is retaliated against.
- c. The CONTRACTOR shall comply with the applicable requirements of the Model Compliance Plan for HMOs when the final model plan is issued by the U.S. Department of Health and Human Services, the Office of Inspector General (OIG).
- d. The CONTRACTOR shall designate an officer or director in its organization who has the responsibility and authority for carrying out the provisions of the fraud and abuse compliance plan.

2-10 Reporting Requirements

2-10.1 General Requirements

The CONTRACTOR is responsible for complying with all the reporting requirements established by TENNCARE. TENNCARE shall provide the CONTRACTOR with the appropriate reporting formats, instructions, submission timetables, and technical assistance when required. TENNCARE may, at its discretion, require the CONTRACTOR to submit new reports, to recreate, reconstruct or re-sort reports using the same or different reporting formats, instructions and submission timetables as specified by TENNCARE. Requests to submit new reports, recreate,

reconstruct or re-sort said reports may be considered Ad Hoc reports or continuous reports and shall be due in accordance with the provisions in Section 6.8.2.1 of this Agreement. The minimum data elements required for reporting are outlined in Attachment XII of this Agreement.

All electronic reports should be submitted to the TennCare Information Systems Section and two (2) copies of all hard-copy reports should be submitted to the Division of Contract Compliance, unless otherwise specified. TENNCARE may authorize the CONTRACTOR to submit reports via e-mail in place of hard copy reports.

Failure to report information, as specified by TENNCARE, shall result in the assessment of liquidated damages as described in Section 6.8.2 of this Agreement.

2-10.2 Reporting Enrollee Information

The CONTRACTOR shall comply with reporting requirements that are developed by TENNCARE in order to reconcile TENNCARE/CONTRACTOR enrollment files and verify that both TENNCARE and the CONTRACTOR maintains accurate enrollee information.

2-10.2.1 Enrollee Information, Weekly Reporting

The CONTRACTOR shall submit weekly reports in an electronic format, unless otherwise specified or approved by TENNCARE in writing, which shall serve as the source of information for a change in the enrollee's TennCare information. Such information shall serve as the source of information for a change in the enrollee's address and/or selection of MCO plan. This report shall include enrollees who move outside the CONTRACTOR's service area as well as enrollees who move to a new address within the CONTRACTOR's service area. The CONTRACTOR agrees to work with the State to devise a methodology to use returned mail to identify enrollees who have moved and whose whereabouts is unknown.

Within ninety (90) days of the time that TENNCARE develops and describes to the CONTRACTOR the new reporting procedures, the CONTRACTOR shall also be required to include in the report described above any information which is known by the CONTRACTOR that may affect an enrollee's TennCare eligibility and/or cost sharing responsibilities including changes in income, family size, access to health insurance, third party resources including any known insurance policies and/or legal actions, proof of uninsurability including limited coverage and exclusionary riders to policies, whether or not the enrollee is incarcerated, or resides outside the State of Tennessee. The minimum data elements that will be required for this report can be found in Attachment XII, Exhibit A of this Agreement.

2-10.2.2 Enrollee Verification Information, On Request

TENNCARE may provide the CONTRACTOR with a report in electronic format containing enrollees, including "potential ineligible" who are enrolled in TennCare Select, for whom TENNCARE has been unable to locate or verify various types of pertinent information. Upon receipt of this report, the CONTRACTOR shall immediately, or within time frames, if any, specified by TENNCARE, provide TENNCARE with any information that is known by the CONTRACTOR that may affect an enrollee's TennCare eligibility and/or cost sharing responsibilities including changes in income, family size, access to health insurance, third party resources including any known insurance policies and/or legal actions, proof of uninsurability, including limited coverage and exclusionary riders to policies, information regarding an enrollee which has been incarcerated, change of residence or residence outside the State of Tennessee. TENNCARE shall not specify timeframes less than thirty (30) calendar days from the CONTRACTOR's receipt of such report. The minimum data elements required for this report can be found in Attachment XII, Exhibit B of this Agreement

2-10.2.3 Eligibility and Administrative Payment Reconciliation

On a monthly basis, the CONTRACTOR shall reconcile enrollee eligibility data and administrative fee payments and submit written verification that the Contractor has an enrollment record for all enrollees for whom the Contractor has received an administrative fee payment. The CONTRACTOR shall also notify

TennCare in the event it has enrollees for whom an administrative payment has not been made or an incorrect payment has been made.

2-10.2.4 Enrollee Cost Sharing

In accordance with Section 2-4.10, the CONTRACTOR shall report enrollee cost-sharing liabilities on a quarterly basis in the manner and form described by TennCare.

2-10.2.5 Children in State Custody

Until such time as an indicator for children in state custody and children transitioning out of state custody can be added to the daily eligibility updates received from TennCare, the CONTRACTOR shall reconcile enrollee eligibility data and administrative fee payments received from TennCare with an adhoc report mutually agreed to by TennCare and the CONTRACTOR to facilitate timely identification of children in state custody or children transitioning out of state custody. The CONTRACTOR shall provide a listing of any enrollees for whom it has conflicting information to TennCare within ten days of the last day of each month.

2-10.2.6 Deceased Enrollee Reconciliation

On a quarterly basis, the CONTRACTOR shall provide to TennCare a listing of any enrollees for whom it has received notification of death in the form and format specified by TennCare. The CONTRACTOR agrees said information may be used as the basis to retroactively recoup administrative fee payments made to the CONTRACTOR after the enrollee's date of death.

2-10.3 Provider Enrollment Reporting

2-10.3.1 Monthly Provider Enrollment File

The CONTRACTOR shall furnish to TENNCARE at the beginning of the Agreement period an electronic report in the format specified by TENNCARE listing all providers enrolled in the TennCare plan, including but not limited to, physicians, dentists, hospitals, home health agencies, pharmacies, medical vendors, ambulance, etc. This listing shall include regularly enrolled providers, specialty or referral providers and any other provider, which may be enrolled for purposes of payment for services provided out-of-plan. The minimum data elements required for all provider listings required in this Section may be found in Attachment XII, Exhibit C of this Agreement. The CONTRACTOR shall be required to inquire as to the provider's race and/or national origin and shall report to TENNCARE the information, if any, furnished by the provider in response to such an inquiry. The CONTRACTOR shall be prohibited from requiring the provider to declare race and/or national origin and shall not utilize information regarding race or national origin obtained pursuant to such request as a basis for decisions regarding participation in the CONTRACTOR's provider network or in determination of compensation amounts.

Thereafter, an electronic provider file shall be submitted on a monthly basis by the 5th of each month. This information shall be used to determine CONTRACTOR compliance with network adequacy standards and shall be used in conjunction with encounter data.

Each provider shall be identified by a unique identifying provider number (i.e., each servicing provider in a group or clinic practice must be identified by a separate provider number). The unique identifying provider number shall be either the Medicaid servicing provider number.

Within ten (10) working days of a request by TENNCARE, the CONTRACTOR shall provide an unduplicated listing of all contracted providers, in a format designated by TENNCARE.

Failure to report the provider information, as specified above, shall result in the application of liquidated damages as described in Section 6.7.2 of this Agreement.

2-10.3.2 Essential Hospital Services Chart

In accordance with Section 2-4.1 the CONTRACTOR shall submit a listing of essential hospital providers that are included in the CONTRACTOR's provider network on the Essential Hospital Services Chart in Attachment XII, Exhibit D within thirty (30) calendar days of Agreement execution and thereafter by September 1 of each year for each of the Grand Regions in which it operates.

2-10.3.3 Specialty Physician Services Chart

In accordance with Section 2-4.1 the CONTRACTOR shall submit a listing of specialty physician arrangements that the CONTRACTOR has in place on the Specialty Physician Services Chart in Attachment XII, Exhibit E within 30 days of Agreement execution and thereafter by September 1 of each year, for each of the community service areas in which it is authorized to serve.

2-10.4 Reporting of Other Insurance

If the CONTRACTOR operates or administers any non-Medicaid HMOs, health plan(s) or other lines of business, the CONTRACTOR agrees to assist TENNCARE with the identification of enrollees with access to other insurance. The method and procedure for identifying enrollees shall be mutually agreed upon by the CONTRACTOR and the State. The proposed minimum data elements that may be requested to assist with the identification of enrollees with access to other insurance can be found in Attachment XII, Exhibit F of this Agreement.

2-10.5 Individual Encounter Reporting

Individual encounter/claim data shall be reported in a standardized format as specified by TENNCARE and transmitted electronically to TENNCARE on a monthly basis by the 15th of each month. In the event a national standardized encounter reporting format is developed, the CONTRACTOR agrees to implement this format if directed to do so by TENNCARE. The minimum data elements required to be provided are identified in Attachment XII, Exhibit G of this Agreement.

The CONTRACTOR shall submit encounter data to the state during the term of this Agreement and beyond, until all such claims incurred during the term of this Agreement have been paid. Data shall be submitted in the format specified by TennCare. The CONTRACTOR shall ensure that all claims processed for payment have industry standard diagnosis and procedure codes and valid Medicaid provider numbers.

2-10.6 Weekly Claims Activity Reporting

The CONTRACTOR shall provide claims processing status reports to TENNCARE on a weekly basis. This report should be provided in the format specified in Attachment XII, Exhibit H of this Agreement until such time as it is modified by TENNCARE. Within ninety (90) days of the time that TENNCARE develops and describes to the CONTRACTOR the new reporting procedures, the CONTRACTOR shall comply with the new reporting procedure.

1. The number of unpaid claims in inventory by service type;
2. An aging of unpaid claims by service type;
3. The average time from receipt to final payment of claim by service type; and
4. The approximate value of unpaid claims by service type.

Failure to report the claims information, as specified above and in Attachment XII, Exhibit H, or as subsequently modified, shall result in the application of liquidated damages as described in Section 6-8 of this Agreement.

2-10.7 Weekly Activity Reporting

The CONTRACTOR shall provide weekly activity reports to TENNCARE that include the following:

1. Number of member phone calls;

2. Abandonment rate for member calls;
3. The approximate waiting time for member response;
4. Number of provider phone calls for prior authorization;
5. The approximate waiting time spent on the phone in queue for providers requesting prior authorization; and
6. The number of provider complaints received, either in writing or by phone.

The minimum data elements and required format can be found in Attachment XII, Exhibit I of this Agreement.

2-10.8 Network Clearing House Reporting

The CONTRACTOR agrees to participate in a statewide effort to tie all hospitals, physicians, and other providers' information into a clearinghouse of information. The information to be reported shall include, but is not limited to, claims information, formulary information, medically necessary service information, cost sharing information and a listing of providers by specialty for each managed care organization.

2-10.8.1 Eligibility Web Site

TENNCARE will develop and implement a secure and enhanced eligibility web site. The goal will be to make the site available on a seven (7) day a week, twenty four hour (24) a day basis to stakeholders, TennCare Bureau, CONTRACTORS, PCP providers, specialists, facilities and members to access appropriate member information including member eligibility, certain agreed upon demographic information and care management status. The exact data elements, procedures for updating such data and security mechanisms will be defined in a series of joint application design sessions between several cross-functional teams from all stakeholders or their representatives. To make such a site useful, an initial database load and periodic updates will be necessary from the source system available from each stakeholder's organization. Agreements will be put in place assuring full participation.

2-10.8.2 Claims Payment Status Web Site

At such time that TENNCARE requires, the CONTRACTOR shall participate and cooperate with TENNCARE in any manner necessary in order to assure that certain claims payment eligibility information can be accessed via the Internet. At TENNCARE's request, the CONTRACTOR shall submit to TENNCARE for approval a plan that outlines educational activities undertaken by the CONTRACTOR to encourage and facilitate provider use of electronic billing. This provision shall not be construed to imply that TENNCARE will require all educational activities be approved by TENNCARE.

The web site design will take into account recent HIPAA legislation and all such concerns providing security mechanisms that will vary based on the specific user. All information will conform to standards for electronic datasets as defined by HIPAA, as they become available.

2-10.9 Financial Reporting

The CONTRACTOR shall file with the Tennessee Department of Commerce and Insurance, TennCare Division, a report on the form prescribed by the National Association of Insurance Commissioners for health maintenance organizations, on or before March 1 of each calendar year, which report is currently required to be filed by all licensed health maintenance organizations pursuant to Tennessee Code Annotated 56-32-208. This annual report shall also contain a supplemental income statement for TennCare Select detailing the CONTRACTOR's fourth quarter and year-to-date revenues earned and expenses paid as a result of the CONTRACTOR's administration of TennCare Select. The CONTRACTOR in preparing this annual report shall comply with any and all rules and regulations of the Tennessee Department of Commerce and Insurance related to the preparation and filing of this report.

The CONTRACTOR shall file with the Department of Commerce and Insurance, TennCare Division, a quarterly financial report on the form prescribed by the National Association of Insurance Commissioners for health maintenance organizations. These quarterly reports shall be filed on or before June 1 (covering first quarter of current year), September 1 (covering second quarter of current year) and December 1 (covering third quarter of

current year) of each calendar year. Each quarterly report shall also contain a supplemental income statement detailing the CONTRACTOR's quarterly and year-to-date revenues earned and expenses paid as a result of the CONTRACTOR's administration of TennCare Select.

The CONTRACTOR shall also cause an audit to be performed by a licensed certified public accountant of its business transactions, including but not limited to the financial transactions made under this Agreement. Such audit shall be performed in accordance with General Accepted Auditing Standards. The CONTRACTOR shall submit to the Tennessee Department of Commerce and Insurance, TennCare Division, the audited financial statements (prepared under generally accepted accounting principles) covering the previous calendar year by May 1 of each calendar year. The audited financial statements shall include the following:

1. a supplemental income statement addressing the TennCare Select operations of the CONTRACTOR,
2. a reconciliation of the audited financial statements to the National Association of Insurance Commissioners annual report filed with the Tennessee Department of Commerce and Insurance, TennCare Division,
3. a summary of transactions between the CONTRACTOR and the CONTRACTOR's related parties, including a non-affiliated management company, using the format prescribed by TDCI. For the purpose of identifying the CONTRACTOR's related parties, "affiliate" and "control" shall have the same definitions as those set forth in Tennessee Code Annotated, Section 56-11-201 and the definition of "affiliate" set forth in TCA Section 56-32-202, and
4. A breakdown of actual administrative expenses into the following components: Subcontractor Costs, Member Services, Network Development and Management, Claims Processing, Utilization Management, Quality Assurance, Marketing, and Other Costs.

The agreement for such audits shall be subject to prior approval of the Comptroller of the Treasury and must be submitted on the standard "Contract to Audit Accounts". In the event that terms included in the standard contract to audit accounts differ from those contained in the TennCare Agreement, the TennCare Agreement takes precedent. These financial reporting requirements shall supersede any other reporting requirements required of the CONTRACTOR by the Tennessee Department of Commerce and Insurance, and the Tennessee Department of Commerce and Insurance shall enact any necessary rule or regulation to conform to this provision of the Agreement.

2-10.10 Reporting CONTRACTOR Administrative and Staffing Information

The CONTRACTOR shall report administrative and staffing information to TENNCARE as described in Section 2-9.2 of this Agreement, including but not limited to the following:

2-10.10.1 Title VI

Title VI reporting shall be in a format described and/or agreed upon by TENNCARE and shall be consistent with the requirements set forth in Section 2-24 of this Agreement;

2-10.10.2 Contact Persons

The CONTRACTOR shall identify staff to TENNCARE as described in Section 2-9.2 of this Agreement.

2-10.10.3 Board of Directors

The CONTRACTOR shall provide to TENNCARE, in writing, a list of all officers and members of the CONTRACTOR's Board of Directors. The CONTRACTOR shall notify TENNCARE, in writing, within ten (10) business days of any change thereto.

Upon request by TENNCARE, the CONTRACTOR shall report to TENNCARE any information requested to verify compliance with the staffing and Title VI or elsewhere in this Agreement.

Failure to report staffing information, as required by TENNCARE, may result in the application of liquidated damages as described in Section 6.2 of this Agreement.

2-10.11 Cost and Utilization Summaries

The CONTRACTOR shall provide the reports specified below separately for each of the following populations:

- (1) Children in State custody and children who are transitioning out of state custody (Groups 1.A and 1.B);
- (2) Children who are SSI eligible (Group 2); and
- (3) All other enrollees.

2-10.11.1 *Prescription Drug Summary*

The CONTRACTOR shall provide a listing of the top 25 prescription drug therapeutic classes by amount paid on a quarterly basis. Said report shall include the therapeutic class, number of units, number of prescriptions filled, dispensing fee, ingredient cost and total amount paid.

2-10.11.2 *Top 25 Providers by Amount Paid*

The CONTRACTOR shall provide a summary listing of the top 25 providers by amount paid on a quarterly basis. Said report shall include the name, address, provider type, and total amount paid for each provider.

2-10.11.3 *Top 25 Inpatient Diagnosis by Frequency and Amount Paid*

The CONTRACTOR shall identify and report to TennCare the top 25 most frequent inpatient diagnosis based on: (1) number of admissions; and (2) amount paid, on a quarterly basis.

2-10.11.4 *Top 25 Outpatient Diagnosis by Frequency and Amount Paid*

The CONTRACTOR shall identify and report to TennCare the top 25 most frequent outpatient diagnosis based on: (1) number of admissions; and (2) amount paid, on a quarterly basis.

2-10.11.5 *Top 10 Inpatient Surgical / Maternity Procedures by Frequency and Amount Paid*

The CONTRACTOR shall identify and report to TennCare the top 10 most frequent inpatient surgical/maternity procedures based on: (1) number of admissions; and (2) amount paid, on a quarterly basis.

2-10.11.6 *Top 10 Outpatient Surgical /Maternity Procedures by Frequency and Amount Paid*

The CONTRACTOR shall identify and report to TennCare the top 10 most frequent outpatient surgical/maternity procedures based on: (1) number of procedures; and (2) amount paid, on a quarterly basis.

2-10.11.7 *High-Cost Claimants*

The CONTRACTOR shall identify and report to TennCare the number of enrollees who incurred claims in excess of a threshold to be determined by the Bureau on a rolling quarterly basis. The CONTRACTOR shall report the enrollee's age, sex, primary diagnosis, and amount paid by claim type for each enrollee. The name of the member shall be blinded in order to maintain confidentiality.

2-10.12 FQHC Reporting

In accordance with the HCFA Terms and Conditions to the TennCare Waiver, FQHC reporting information shall be submitted to TENNCARE on an annual basis using the form in Attachment XII, Exhibit K. This hard copy annual report shall be due by January 1 each year.

2-10.13 Appeals and Resolution

In accordance with Section 2-8 the CONTRACTOR shall provide a hard copy quarterly report of appeals and resolution to the Director of the TennCare Solutions Unit, by the 30th of the following month.

Failure to provide quarterly reports of appeals and resolution, as specified above and in Attachment XII Exhibit L, shall result in the application of liquidated damages as described in Section 6-8 of this Agreement.

2-10.14 Quality Monitoring Reports

2-10.14.1 Continuous Focused Studies

In accordance with Attachment II, the CONTRACTOR is required to monitor and evaluate, at a minimum, care and services in priority areas selected by TENNCARE. Two of the clinical areas of concern selected by TENNCARE and one of the health services delivery areas of concern shall be required for continuous evaluation and study if applicable to the patient population. The CONTRACTOR shall submit a hard copy report of the study design, analysis and results, for each continuous focused study to TENNCARE on an annual basis.

2-10.14.2 Quarterly Focused Studies

In accordance with Attachment II, the CONTRACTOR is required to select at least one area of concern, in addition to areas of concerns being studied on an on-going basis, to study on a quarterly basis. At the end of each quarter, the CONTRACTOR shall submit a hard copy report of the study design, analysis and results, to TENNCARE.

2-10.14.3 Continuity of Care Reporting

In accordance with Attachment II, the CONTRACTOR shall submit a hard copy report to TENNCARE the total number of enrollees in Groups 2 through 6 and percentage of total enrollees in each Grand Region that have not been assigned to a primary care provider (PCP) within 30 days of enrollment on a quarterly basis, within 30 days of the end of the quarter.

For the purpose on reporting PCP assignment for enrollees in Groups 1.A and 1.B, the CONTRACTOR shall report to TENNCARE the total number of enrollees and percentage of total enrollees in each Grand Region that have not been assigned to a Best Practice Network Primary Care Provider within 30 days of enrollment on a quarterly basis, within 30 days of the end of the quarter.

2-10.14.4 Performance Indicator Reporting

Performance indicator results for the performance indicators specified in Attachment II shall be submitted to the State within 90 days of the end of the calendar year, unless an alternative reporting timeframe is agreed upon by the Performance Indicator workgroup.

2-10.15 Network Management

2-10.15.1 Out-of-Network Utilization

As specified in Section 2-9.4, the CONTRACTOR shall maintain a procedure to identify enrollees by PCP panel who establish a pattern of utilizing non-network providers. Management reports designed to support this requirement shall be submitted to the state on a quarterly basis the results.

2-10.15.2 Emergency Room Utilization

As specified in Section 2-9.4, the CONTRACTOR shall maintain a procedure to identify enrollees by PCP panel who establish a pattern of use of the emergency room. Management reports designed to support this requirement shall be submitted to the state on a quarterly basis the results.

2-10.15.3 Specialty Utilization

As specified in Section 2-9.4, the CONTRACTOR shall maintain a procedure to identify utilization of specialists by Primary Care Provider enrollee panel. Management reports designed to support this requirement shall be submitted to the state on a quarterly basis the results.

2-11 Accounting Requirements

The CONTRACTOR shall establish and maintain an accounting system in accordance with generally accepted accounting principles. The accounting system shall maintain records pertaining to the tasks defined in this Agreement and any other costs and expenditures made under the Agreement.

Specific accounting records and procedures are subject to TENNCARE and Federal approval. Accounting procedures, policies, and records shall be completely open to state and federal personnel at any time during the Agreement period and for five (5) years thereafter.

2-12 Availability of Records

- a. The CONTRACTOR shall insure within its own organization and pursuant to any agreement the CONTRACTOR may have with other providers of service, that TENNCARE representatives and authorized federal, state and Comptroller personnel shall have immediate and complete access to all records pertaining to the medical care or services provided to TennCare enrollees.
- b. The CONTRACTOR shall make all records available at the CONTRACTOR's expense for review, audit, or evaluation by authorized federal, state, and Comptroller of Treasury personnel. Access will be during normal business hours and will be either through on-site review of records or through the mail. All records to be sent by mail will be sent to TENNCARE within twenty (20) working days of request unless otherwise specified by TENNCARE or TennCare rules and regulations. Requested records shall be provided at no expense to TENNCARE. Records related to appeals shall be forwarded within the time frames specified in the appeal process portion of this Agreement. Such requests made by TENNCARE shall not be unreasonable.
- c. That CONTRACTOR, any CONTRACTOR's management company and any CONTRACTOR's claims processing subcontractor shall cooperate with the State, or any of the State's contractors and agents during the course of any claims processing, financial or operational examinations. This cooperation shall include, but shall not be limited to the following:

1. Providing full cooperation and direct and unrestricted access to facilities, information, and staff, including facilities, information and staff of any management company or sub-contractor, to the State or any of the State's contractors and agents.
2. Maintaining full cooperation and open authority for claims processing systems access and mailroom visits by TDCI or designated representatives and to cooperate fully with detail claims testing for claims processing system compliance.
3. Allowing for periodic review to ensure that all discounts, special pricing considerations and financial incentives have accrued to the State and that all costs incurred are in accordance with the Contract. The CONTRACTOR shall provide the auditor access to all information necessary to perform the examination.
4. The CONTRACTOR shall cooperate fully with audits the State may conduct of medical management to include clinical processes and outcomes, internal audits, provider networks, and any other aspect of the program the State deems appropriate. The State may select any qualified persons, or organization to conduct the audits.

2-13 Audit Requirements

The CONTRACTOR shall maintain books, records, documents, and other evidence pertaining to the administrative costs and expenses incurred pursuant to this Agreement as well as medical information relating to the individual enrollees for the purposes of audit requirements. Records other than medical records may be kept in an original paper state or preserved on micro media or electronic format. Medical records shall be maintained in their original form or may be converted to electronic format as long as the records are readable and/or legible. These records, books, documents, etc., shall be available for review by authorized federal, state, and Comptroller personnel during the Agreement period and five (5) years thereafter, except if an audit is in progress or audit findings are yet unresolved in which case records shall be kept until all tasks are completed. During the Agreement period, these records shall be available at the CONTRACTOR's chosen location subject to the approval of TENNCARE. If the records need to be sent to TENNCARE, the CONTRACTOR shall bear the expense of delivery. Prior approval of the disposition of CONTRACTOR, subcontractor or provider records must be requested and approved by TENNCARE.

2-14 Independent Review of the CONTRACTOR

In accordance with Chapter 4 of the waiver approved by the Health Care Financing Administration (HCFA), HCFA may select a PRO, Private Accreditation Organization or an External Quality Review Organization (EQRO) to provide a periodic or an annual independent review of the CONTRACTOR. The results of the review shall be provided to TENNCARE and to the CONTRACTOR and shall be available, on request, to the Department of Health and Human Services, the Office of Inspector General and General Accounting Office.

2-15 Accessibility for Monitoring

For purposes of monitoring under this Agreement, the CONTRACTOR shall make available to TENNCARE or its representative and other authorized state and federal personnel, all records, books, documents, and other evidence pertaining to this Agreement, as well as appropriate administrative and/or management personnel who administer the plan. The monitoring shall occur periodically during the Agreement period and may include announced or unannounced visits, or both.

2-16 Changes Resulting from Monitoring and Audit

The CONTRACTOR shall, as soon as is practical and no later than sixty (60) calendar days after a notice of deficiencies is received, unless justified and agreed upon by TENNCARE, comply with all recommendations made in writing by TENNCARE, pursuant to Agreement items found not in compliance as a result of any day to day monitoring activities or any other authorized monitoring report or audit. A written plan to correct cited deficiencies and a time frame for completion of said plan must be submitted to TENNCARE by the CONTRACTOR within fifteen (15) working days after receipt of notice of deficiencies or as soon as practical, whichever is the lesser. TENNCARE may extend or reduce the time frame for corrective action where, in its opinion, it is reasonable and advisable to do so. The CONTRACTOR shall be responsible for assuring corrective action when a subcontractor's or provider's quality of care is inadequate. TENNCARE reserves the right to suspend enrollment in the plan if it is determined that quality of care is inadequate.

In the event the CONTRACTOR fails to complete the actions required by the corrective action plan within the time frame specified, the CONTRACTOR agrees that TENNCARE shall assess the liquidated damages and/or intermediate sanctions as specified in Section 6.7 of this Agreement, or if the deficiencies are severe, that TENNCARE may terminate the Agreement for cause as described in Section 6.2 of this Agreement. The CONTRACTOR further agrees that any liquidated damages assessed by TENNCARE shall be due and payable to TENNCARE within thirty (30) calendar days of notice of damages and if payment is not made by the due date, said liquidated damages may be withheld from future administrative payments by TENNCARE without further notice.

This Section shall apply to any corrective action requirements not otherwise specifically addressed.

2-17 Use of Subcontractors

- a. Legal Responsibility. The CONTRACTOR shall be responsible for the administration and management of all aspects of this Agreement and the health plan covered thereunder. If the CONTRACTOR elects to utilize a subcontractor, the CONTRACTOR shall assure that the subcontractor shall not enter into any subsequent agreements or subcontracts for any of the work contemplated under the subcontractor for purposes of this Agreement, without approval of the CONTRACTOR. No subcontract, provider agreement or other delegation of responsibility terminates or reduces the legal responsibility of the CONTRACTOR to TENNCARE to assure that all activities under this Agreement are carried out.
- b. Prior approval. All subcontracts and revisions thereto, as defined in Section 1-3 of this Agreement, shall be approved in advance by TENNCARE. All subcontracts shall be maintained in accordance with the applicable terms of this Agreement. Once a subcontract has been executed by all of the participating parties, a copy of the fully executed subcontract shall be sent to the State within 30 days of execution.
- c. Quality of Care Monitors. If the subcontract is for the purpose of securing the provision of enrollee benefits, the subcontract must specify that the subcontractor must adhere to the Quality of Care Monitors included in the Agreement as Attachment II. The Quality of Care Monitors shall be included as part of the subcontract between the CONTRACTOR and the subcontractor or provided separately at the time the subcontract is executed, provided however, if the Quality of Care Monitors is not included in the subcontract, it shall be referenced in the agreement as being provided separately upon execution of the subcontract.
- d. Children in State Custody. The CONTRACTOR must include in its subcontracts and agreements with providers a provision that states that subcontractors and providers are not permitted to encourage or suggest, in writing or verbally, that TennCare children be placed into state custody in order to receive medical or behavioral services covered by TENNCARE.
- e. Assignability. Upon the next renewal of existing transportation and claims processing subcontracts or upon execution of transportation and claims processing subcontracts, said subcontract agreements must include language that requires that the subcontract agreement shall be assignable from the CONTRACTOR to the State, or its designee: i) at the State's discretion upon written notice to the CONTRACTOR and the affected subcontractor; or ii) upon CONTRACTOR's request and written approval by the State. Further, the subcontract agreement must include language by which the subcontractor agrees to be bound by any

such assignment, and that the State, or its designee, shall not be responsible for past obligations of the CONTRACTOR.

- f. Claims Processing. All claims for services furnished to a TennCare enrollee filed with the CONTRACTOR must be processed by either the CONTRACTOR or by one (1) subcontractor retained by the organization for the purpose of processing claims. However, another entity can process claims related to pharmacy, vision, dental, lab or transportation if that entity has been retained by the CONTRACTOR to arrange and provide for the delivery of said services.
- g. Notice of Subcontractor Termination. When a subcontract that relates to the provision of services to enrollees or claims processing services is being terminated between the CONTRACTOR and a subcontractor, the CONTRACTOR shall give at least thirty (30) days prior written notice of the termination to TENNCARE and the TennCare Division, TDCI. Such notice shall include, at a minimum, a CONTRACTOR's intent to change to a new subcontractor for the provision of said services, an effective date for termination and/or change, as well as any other pertinent information that may be needed. In addition to prior written notice, the CONTRACTOR shall also provide TENNCARE with a transition plan, when requested, which shall include, at a minimum, information regarding how prior authorization requests will be handled during and after the transition, how continuity of care will be maintained for the enrollees, etc. Failure to adhere to guidelines and requirements regarding administrative responsibilities, including subcontract requirements may result in the application of liquidated damages or intermediate sanctions as described in Section 4-8 of this Agreement. TENNCARE reserves the right to require this notice requirement and procedures for other subcontracts if determined necessary upon review of the subcontract for approval.
- h. Notice of Approval. Approval of subcontracts shall not be considered granted unless TENNCARE issues its approval in writing.

2-18 Provider Agreements

The CONTRACTOR shall assure the provision of all covered services specified in this Agreement. The CONTRACTOR shall enter into agreements with providers and/or provider subcontracting entities or organizations who will provide services to the enrollees in exchange from the State for payment for services rendered.

Provider agreements and amendments thereto do not require prior approval by TENNCARE before taking effect; however, the CONTRACTOR shall not execute provider agreements with providers who have been excluded from participation in the Medicare and/or Medicaid programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with the TENNCARE program. Further, all template provider agreements and revisions thereto must be approved in advance by the TennCare Division, Department of Commerce and Insurance in accordance with statutes regarding the approval of an HMOs certificate of authority (COA) and any material modifications thereof.

All provider agreements executed by the CONTRACTOR, and all provider agreements executed by subcontracting entities or organizations, pursuant to this Section shall, at a minimum, meet the following requirement (No other terms or conditions agreed to by the CONTRACTOR and provider shall negate or supersede the following requirements):

- a. Be in writing. All new provider agreements and existing provider agreements as they are renewed, must include a signature page which contains CONTRACTOR and provider names which are typed or legibly written, provider company with titles, and dated signatures of all appropriate parties.
- b. Specify the effective dates of the provider agreement;
- c. Specify in the provider agreement that the provider agreement and its attachments contain all the terms and conditions agreed upon by the parties;
- d. Assure that the provider shall not enter into any subsequent agreements or subcontracts for any of the work contemplated under the provider agreement without approval of the CONTRACTOR;

- e. Identify the population covered by the provider agreement;
- f. Specify that the provider may not refuse to provide medically necessary or covered preventive services to a TennCare patient under this Agreement for non-medical reasons, including, but not limited to, failure to pay applicable cost sharing responsibilities. However, the provider shall not be required to accept or continue treatment of a patient with whom the provider feels he/she cannot establish and/or maintain a professional relationship;
- g. Specify the functions and/or services to be provided by the provider and assure that the functions and/or services to be provided are within the scope of his/her professional/technical practice;
- h. Specify the amount, duration and scope of services to be provided by the provider;
- i. Provide that emergency services be rendered without the requirement of prior authorization of any kind;
- j. If the provider performs laboratory services, the provider must meet all applicable requirements of the Clinical Laboratory Improvement Act (CLIA) of 1988 at such time that HCFA mandates the enforcement of the provisions of CLIA;
- k. Require that an adequate record system be maintained for recording services, servicing providers, charges, dates and all other commonly accepted information elements for services rendered to enrollees pursuant to the agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the provider agreement). Enrollees and their representatives shall be given access to the enrollees' medical records, to the extent and in the manner provided by T.C.A. Sections 63-2-101 and 63-2-102, and, subject to reasonable charges, be given copies thereof upon request. When a patient-provider relationship with a TennCare primary care provider ends and the enrollee requests that medical records be sent to a second TennCare provider who will be the enrollee's primary care case manager or gatekeeper, the first provider shall not charge the enrollee or the second provider for providing the medical records;
- l. Require that any and all records be maintained for a period not less than five (5) years from the close of the agreement and retained further if the records are under review or audit until the review or audit is complete. Said records shall be made available and furnished immediately upon request for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring upon request of authorized representative of the CONTRACTOR or TENNCARE and authorized federal, state and Comptroller personnel;
- m. Provide that TENNCARE, U.S. Department of Health and Human Services, and Office of Inspector General Comptroller shall have the right to evaluate through inspection, whether announced or unannounced, or other means any records pertinent to this Agreement including quality, appropriateness and timeliness of services and such evaluation, and when performed, shall be performed with the cooperation of the provider. Upon request, the provider shall assist in such reviews including the provision of complete copies of medical records;
- n. Provide for monitoring, whether announced or unannounced, of services rendered to enrollees sponsored by the CONTRACTOR;
- o. Whether announced or unannounced, provide for the participation and cooperation in any internal and external QM/QI, utilization review, peer review and appeal procedures established by the CONTRACTOR and/or TENNCARE;
- p. Specify that the CONTRACTOR shall monitor the quality of services delivered under the agreement and initiate corrective action where necessary to improve quality of care, in accordance with that level of medical care which is recognized as acceptable professional practice in the respective community in which the provider practices and/or the standards established by TENNCARE;
- q. Require that the provider comply with corrective action plans initiated by the CONTRACTOR;

- r. Provide for submission of all reports and clinical information required by the CONTRACTOR;
- s. Require safeguarding of information about enrollees according to applicable state and federal laws and regulations and as described in Section 2 of this Agreement;
- t. Provide the name and address of the official payee to whom payment shall be made;
- u. Make full disclosure of the method and amount of compensation or other consideration to be received from the CONTRACTOR;
- v. Provide for prompt submission of information needed to make payment;
- w. Provide for payment to the provider upon receipt of a clean claim properly submitted by the provider within the required timeframes as specified in T.C.A 56-32-226 and Section 2-9.g of this Agreement;
- x. Specify the provider shall accept payment or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payor) plus the amount of any applicable cost sharing responsibilities, as payment in full for covered services provided and shall not solicit or accept any surety or guarantee of payment from the enrollee in excess of the amount of applicable cost sharing responsibilities. Enrollee shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the patient being served;
- y. Specify that at all times during the term of the agreement, the provider shall indemnify and hold TENNCARE harmless from all claims, losses, or suits relating to activities undertaken pursuant to the Agreement between TENNCARE and the MCO. This indemnification may be accomplished by incorporating Section 6-18 of the TENNCARE/MCO Agreement in its entirety in the provider agreement or by use of other language developed by the MCO and approved by TENNCARE.
- z. Require the provider to secure all necessary liability and malpractice insurance coverage as is necessary to adequately protect the Plan's enrollees and the CONTRACTOR under the agreement. The provider shall provide such insurance coverage at all times during the agreement and upon execution of the provider agreement furnish the CONTRACTOR with written verification of the existence of such coverage;
- aa. Specify both the CONTRACTOR and the provider agree to recognize and abide by all state and federal laws, regulations and guidelines applicable to the health plan;
- bb. Provide that the agreement incorporates by reference all applicable federal and state laws, TennCare rules and regulations or court orders, and revisions of such laws or regulations shall automatically be incorporated into the agreement, as they become effective. In the event that changes in the agreement as a result of revisions and applicable federal or state law materially affect the position of either party, the CONTRACTOR and provider agree to negotiate such further amendments as may be necessary to correct any inequities;
- cc. Specify procedures and criteria for any alterations, variations, modifications, waivers, extension of the agreement termination date, or early termination of the agreement and specify the terms of such change. If provision does not require amendments be valid only when reduced to writing, duly signed and attached to the original of the agreement, then the terms must include provisions allowing at least thirty (30) days to give notice of rejection and requiring that receipt of notification of amendments be documented (e.g., Certified Mail, facsimile, hand-delivered receipt, etc);
- dd. Specify that both parties recognize that in the event of termination of this Agreement between the CONTRACTOR and TENNCARE for any of the reasons described in Section 6-2 of this Agreement, the provider shall immediately make available to TENNCARE, or its designated representative, in a usable form, any or all records, whether medical or financial, related to the provider's activities undertaken pursuant to the MCO/provider agreement. The provision of such records shall be at no expense to TENNCARE;

- ee. Include provisions for resolution of disputes by arbitration. Specify that the TennCare Provider Independent Review of Disputed Claims process shall be available to providers to resolve non-emergency claims denied in whole or in part by the MCO as provided at T.C.A. 56-32-226(b).
- ff. Include a conflict of interest clause as stated in Section 6-7 of this Agreement between the CONTRACTOR and TENNCARE;
- gg. Specify the extent to which any savings or loss realized by the plan shall be shared with the providers;
- hh. Specify that the provider shall be required to accept TennCare reimbursement amounts for services provided under the agreement between the provider and CONTRACTOR to TennCare enrollees and shall not be required to accept TennCare reimbursement amounts for services provided to persons who are covered under another health plan operated or administered by the CONTRACTOR;
- ii. Specify that the provider must adhere to the Quality of Care Monitors included in this Agreement as Attachment II;
- jj. Specify that a provider shall have at least one hundred and twenty (120) calendar days from the date of rendering a health care service to file a claim with the CONTRACTOR and no more than one hundred eighty (180) calendar days from the date of rendering a health care service to file an initial claim with the CONTRACTOR except in situations regarding coordination of benefits or subrogation in which case the provider is pursuing payment from a third party or if an enrollee is enrolled in the plan with a retroactive eligibility date. In situations of enrollment in the plan with a retroactive eligibility date, the minimum and maximum time frames for filing a claim shall begin on the date that the CONTRACTOR receives notification from TENNCARE of the enrollee's eligibility;
- kk. Specify that the provider will comply with the appeal process including but not limited to assisting an enrollee by providing appeal forms and contact information including the appropriate address for submitting appeals for state level review;
- ll. Require that the provider display notices of the enrollee's right to appeal adverse action affecting services in public areas of their facility(s) in accordance with TennCare TennCare rules, subsequent amendments, or any and all Court Orders;
- mm. Require that if any requirement in the provider agreement is determined by TENNCARE to conflict with the Agreement between TENNCARE and the MCO, such requirement shall be null and void and all other provisions shall remain in full force and effect;
- nn. All provider agreements must include language which informs providers of the package of benefits that EPSDT offers and which requires providers to make treatment decisions based upon children's individual medical and behavioral health needs. A listing of the EPSDT benefit package is contained in Attachment IX of this Agreement. All provider agreements must contain language that references the EPSDT benefit package found in Attachment IX and the agreement shall either physically incorporate Attachment IX or include language to require that the attachment be furnished to the provider upon request;
- oo. All provider agreements must include a provision which states that providers are not permitted to encourage or suggest, in writing or verbally, that TennCare children be placed into state custody in order to receive medical or behavioral services covered by TennCare; and
- pp. Specify that in the event that TENNCARE deems the MCO unable to timely process and reimburse claims and requires the MCO to submit provider claims for reimbursement to an alternate claims processor to ensure timely reimbursement, the provider shall agree to accept reimbursement at the MCO's contracted reimbursement rate or the rate established by TennCare, whichever is greater.
- qq. All primary care provider agreements shall specify that its network primary care providers shall submit all claims with a primary behavioral health diagnosis (ICD-9 CM 290.xx – 319.xx) to the BHO for payment.

The CONTRACTOR shall give TENNCARE and the Tennessee Department of Commerce and Insurance, TennCare Division, immediate notification in writing by Certified Mail of any administrative or legal action or complaint filed regarding any claim made against the CONTRACTOR by a provider or enrollee which is related to the CONTRACTOR's responsibilities under this Agreement, including but not limited to notice of any arbitration proceedings instituted between a provider and the CONTRACTOR. The CONTRACTOR shall ensure that all tasks related to the provider agreement are performed in accordance with the terms of this Agreement.

2-19 Fidelity Bonds – Net Worth

The CONTRACTOR shall secure and maintain during the life of this Agreement any fidelity bonds and/or insolvency protection required by the Tennessee Department of Commerce and Insurance. Proof of coverage must be submitted to TENNCARE as a deliverable item pursuant to Attachment I of this Agreement within sixty (60) calendar days after execution of this Agreement and prior to the delivery of health care, which ever comes first.

2-20 Insurance

A non-governmental CONTRACTOR shall not commence any work in connection with this Agreement until it has obtained all the insurance coverage required in this Agreement. Nor shall the CONTRACTOR allow any subcontractors or contract providers to commence work on his or her part of the subcontract or provider agreement until all similar insurance required of the subcontractor or provider has been so obtained. The insurance includes but is not limited to general liability, worker's compensation, and medical malpractice insurance. The CONTRACTOR shall furnish proof of coverage of insurance by a certificate of insurance submitted to TENNCARE as a deliverable item pursuant to Attachment I of this Agreement. Governmental CONTRACTORS must meet this requirement in accordance with the specific statutes that apply.

TENNCARE shall be exempt from and in no way liable for any sums of money that may represent a deductible in any insurance policy. The payment of such a deductible shall be the sole responsibility of the CONTRACTOR, subcontractor and/or provider providing such insurance. The same holds true of any premiums paid on any insurance policy pursuant to this Agreement.

Failure to provide proof of coverage within the specified time period may result in this Agreement being terminated.

2-21 Ownership and Financial Disclosure

The CONTRACTOR shall disclose, to TENNCARE, the Comptroller General or Health Care Financing Administration, full and complete information regarding ownership, financial transactions and persons convicted of criminal activity related to Medicare, Medicaid, or the Federal Title XX programs in accordance with federal and state requirements, including Public Chapter 379 of the Acts of 1999. This disclosure shall be made at times and on forms prescribed by the TENNCARE agency, but no less frequently than on an annual basis to be provided no later than March 1 of each calendar year. The following information shall be disclosed:

- a. The name and address of each person with an ownership or control interest in the disclosing entity or in any provider or subcontractor in which the disclosing entity has direct or indirect ownership of five percent (5%) or more and whether any of the persons named pursuant to this requirement is related to another as spouse, parent, child, or sibling. This disclosure shall include the name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest.
- b. The identity of any provider or subcontractor with whom the CONTRACTOR has had business transactions totaling more than twenty-five thousand dollars (\$25,000) during the twelve (12) month period ending on the date of the disclosure and any significant business transactions between the CONTRACTOR, any wholly owned supplier, or between the CONTRACTOR and any provider or subcontractor, during the five (5) year period ending on the date of the disclosure.

- c. The identity of any person who has an ownership or control interest in the CONTRACTOR, or is an agent or managing employee of the CONTRACTOR and who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Federal Title XX services program since the inception of those programs.
- d. Disclosure from officials in legislative and executive branches of government as to possible conflicts of interest.

TENNCARE and/or the Secretary of Health and Human Services may request information to be in the form of a consolidated financial statement.

2-22 Service Area(s)

2-22.1 Authorized Community Service Area

The State of Tennessee has been divided into twelve (12) geographic areas consisting of one (1) or more counties within a defined geographic area, which correlates to the sources where residents typically receive medical care. These geographic areas have been referred to throughout this Agreement as community service areas (CSA). The CONTRACTOR is required to serve enrollees identified by TennCare who reside in all community service areas within each Grand Region in the State. However, the State has discretion to terminate the CONTRACTOR's participation in any geographic region in which TENNCARE has determined the CONTRACTOR is unable to adequately serve enrollees in compliance with this Agreement.

If for any reason it is determined by TENNCARE that the CONTRACTOR is not adequately serving one or more authorized community service areas, TENNCARE may, at any time, terminate authorization of the community service area(s) and disenroll the enrollees in the community service area from the health plan. Enrollees shall be transferred as the result of voluntary selection or on a non-discriminatory assignment basis to a TennCare health plan that is authorized to serve the community service area.

To the extent possible and practical, TENNCARE shall provide advance notice to all MCOs serving a community service area of the approved opening, closing or limiting of enrollment of any MCO serving the community service area or Grand Region (as defined below) whichever is applicable; however, failure by TENNCARE to provide advance notice shall not limit in any manner the responsibility of each MCO to comply with the terms of this Agreement.

2-22.2 Termination of Community Service Area

Regardless of the reason, if authorization to serve a specific community service area is terminated, the CONTRACTOR shall submit a termination plan as specified in Section 6-2.6 of this Agreement, specific to the community service area being terminated.

2-23 Contractor Appeal Rights

The CONTRACTOR shall have the right to contest TENNCARE decisions pursuant to the provisions of T.C.A. Section 9-8-301 *et. seq.* for the resolution of disputes under this Agreement. Written notice describing the substance and basis of the contested action must be submitted to TENNCARE within thirty (30) calendar days of the action taken by TENNCARE. The CONTRACTOR shall comply with all terms and conditions contained within this Agreement pending the final resolution of the contested action.

2-24 Title VI Information

In order to demonstrate compliance with Federal and State regulations of Title VI of the Civil Rights Act of 1964 the CONTRACTOR shall:

- a. Designate a staff person to be responsible for Title VI compliance on behalf of the CONTRACTOR. The designated staff person shall be identified by name in writing to TENNCARE within thirty (30) days of the effective date of this Agreement. The CONTRACTOR does not have to require that Title VI compliance be the sole function of the designated staff person.
 1. In respect to any period of time that the CONTRACTOR does not have a designated staff person responsible for Title VI compliance it shall be reported to TENNCARE in writing, to the attention of the Title VI Coordinator, within ten (10) calendar days of the commencement of such period of time. At such time that this function is redirected, the name of the staff member who assumed the duties shall be reported to TENNCARE, to the attention of the Title VI Coordinator, within ten (10) calendar days of the change.
- b. On an annual basis, submit a copy of the CONTRACTOR's personnel policies that, at a minimum; emphasize non-discrimination in hiring, promotional, operational policies, contracting processes and participation on advisory/planning boards or committees.
- c. On a quarterly basis, a summary listing totaling the number of supervisory personnel by race/national origin and sex. The CONTRACTOR is required to request this information from all CONTRACTOR staff. CONTRACTOR staff response is voluntary. The CONTRACTOR is prohibited from utilizing information obtained pursuant to such a request as a basis for decisions regarding employment or in determination of compensation amounts. Such listing shall separate categories for total supervisory personnel by; number of male supervisors who are White, Black (not of Hispanic origin), American Indian or Alaskan Native, Asian or Pacific Islander, Hispanic origin and other race/national origin as indicated by staff and number of female supervisors who are White, Black (not of Hispanic origin), American Indian or Alaskan Native, Asian or Pacific Islander, Hispanic origin and other race/national origin females as indicated by staff.
- d. On an annual basis, a summary listing by CSA of servicing providers which includes race or ethnic origin of each provider. The listing shall include, at a minimum, provider name, address, race/ethnic origin (to be indicated as in Section 2-24 and shall be sorted by CSA. Each provider type (e.g., physician, dentist, etc.) shall be reported separately within the CSA. Each provider type (e.g., physician, dentist, etc.) shall be reported separately within the CSA. Primary care providers shall be reported separately from other physician specialties. The CONTRACTOR is required to request this information from all providers. Provider response is voluntary. The CONTRACTOR is prohibited from utilizing information obtained pursuant to such a request as a basis for decision regarding participation in the CONTRACTOR's provider network or in determination of compensation amounts.
- e. On a quarterly basis, a listing of all complaints/appeals filed by employees, enrollees and subcontractors in which discrimination is alleged in the CONTRACTOR's TennCare Plan. Such listing shall include, at a minimum, the identity of the party making the complaint, the circumstances of the complaint/appeal, date complaint/appeal filed, the individual's relationship to the CONTRACTOR, CONTRACTOR's resolution, if resolved, and name of CONTRACTOR staff person responsible for adjudication of the complaint/appeal.
- f. On a quarterly basis, a listing of all requests for translation/interpretation services by requesting enrollee.

Each request reported will identify by name and member identification number the enrollee for which translation/interpretation service was provided, the date of the request, the date provided, and the identification of the translator/interpreter.
- g. On an annual basis, a copy of the CONTRACTOR's policy, that demonstrates non-discrimination in provision of services to persons with Limited English Proficiency.
 1. A listing of the interpreter/translator services utilized by the CONTRACTOR in providing services to enrollees with Limited English Proficiency. The listing shall provide the full name of interpreter/translator services, address of services, phone number of services, hours services are available and be sorted by CSA.
- h. On an annual basis, the CONTRACTOR's Title VI Compliance Plan and Assurance of Non-discrimination.

3 REVISED REMEDIAL PLAN REQUIREMENTS

Children who are in state custody are eligible for participation in the carve-out for children in state custody as described in the Revised Remedial Plan submitted to Federal court on December 18, 2000. The CONTRACTOR agrees to be the designated MCO carve-out entity for the purpose of meeting the requirements of the Revised Remedial Plan and agrees to satisfy all special requirements for the delivery of services to children in state custody enrolled in TennCare Select. The MCO designated requirements specified in Section 3 are in addition to those described in Section 2. Children in state custody are eligible for the same TennCare covered services as other TennCare eligible children. However, due to the special needs of this population and per the Revised Remedial Plan, this Section specifies special requirements for the delivery of TennCare covered services for children who are eligible for participation in the carve-out.

In the event the Revised Remedial Plan is not approved by the court, the CONTRACTOR agrees to participate fully in the implementation of the Remedial Plan for Children in custody as filed with the Federal Court on May 12, 2000 on a schedule determined to be reasonable and in accordance with the requirements of the court.

3-1 CONTRACTOR Responsibilities

The Revised Remedial Plan assigns responsibilities for the administration and operation of the plan to several parties (e.g., the Executive Oversight Committee, the Steering Panel, the Health Services Team, the Department of Children's Services, the Behavioral Health Organization, TennCare and delivery system providers). The CONTRACTOR agrees to arrange for services and administer the plan in collaboration with these other entities. The CONTRACTOR agrees to:

- a. Participate on the Children with Special Health Needs (CSHN) Steering Panel.
- b. Recruit and contract with an adequate number of providers for Best Practice Network (BPN) with expertise in children's health problems in accordance with TennCare standards and the criteria of the Revised Remedial Plan.
- c. Recruit for areas identified by the Health Services Team (HST) as having an inadequate network; contract with qualified and willing providers identified by the Health Services Team for areas (geographical or specialty) where a shortage is identified; OR if consensus cannot be reached with the Health Services Team on what constitutes a network inadequacy, demonstrate adequacy of network to Executive Oversight Committee.
- d. Develop procedures for assigning children in state custody to BPN providers; work with the Steering Panel to develop the best policy and mechanism for maintaining a long standing relationship between a child and a PCP, when family along with providers or the state feel that disruption of this relationship would be detrimental to the child. This is especially critical for children with severe physical or behavioral problems with a long-term relationship with the provider.
- e. The CONTRACTOR agrees to implement and monitor provider use of four best practice guidelines per year which have been drafted in collaboration with the committee appointed by the Steering Panel.
- f. Continue to manage and be responsible for all aspects of the TennCare program as specified in contracts with TennCare. Distribute Best Practice guidelines to Best Practice Network providers when approved by the Steering Panel.

- g. Work with state to develop those services determined to be necessary by CSHN Steering Panel and Executive Oversight Committee.
- h. Provide BPN-PCPs with a listing of BPN behavioral health providers.
- i. Educate BPN-PCPs on medical management policies and coordination of care requirements.
- j. Ensure submission of encounter data from Best Practice Network providers.

3-1.1 Administration and Management

- a. Staff Requirements. A specific Department of Children's Services (DCS) liaison person or persons shall be identified, in writing, to TENNCARE and the DCS thirty (30) calendar days prior to the effective date of this Agreement. The DCS liaison person(s) will be responsible for assisting DCS to assure compliance with EPSDT requirements and the coordination of care for children in custody and at prolonged risk of custody and shall support Best Practice Network Primary Care Providers (BPN-PCPs) as requested. The names, titles, addresses and contact numbers (phone, fax, etc.) shall be provided for each of the liaison persons to TENNCARE, DCS and BPN-PCPs. The liaison person(s) shall be available to TENNCARE and/or the DCS case managers, BPN-PCPs, and foster families for assistance. The number of specific liaison persons identified shall be adequate at all times to cover the number of children in or at prolonged risk of State custody enrolled in TennCare Select. Any staff changes in the identified liaison person(s) shall be reported in writing to TENNCARE, DCS and BPN-PCPs within ten (10) calendar days of the change.

TENNCARE will coordinate the responsibility for training the DCS liaison(s) on issues dealing with the provision of EPSDT services to children in or at prolonged risk of State custody. The liaisons will assist DCS with care coordination for these children and will have the responsibility of facilitating the timely delivery of EPSDT services covered by the MCO. Assistance with care coordination will include identifying providers, scheduling appointments, and coordinating transportation (if appropriate), when requested.

3-1.2 Provider Network

- a. Adequate Capacity. The CONTRACTOR must maintain a provider network with adequate capacity to deliver covered services that meet the special needs of children in state custody. Indicators of an adequate network include:
 1. The CONTRACTOR meets the guidelines established by its contract with TennCare for a provider network (as specified in Section 2 and Section 3);
 2. The CONTRACTOR has enough providers to consistently meet the time lines of this plan for EPSDT screenings;
 3. The CONTRACTOR has sufficient types and numbers of providers to be able to consistently deliver services in a timely manner when ordered for a child.
- b. Provider Network Composition. In addition to maintaining a provider network in accordance with Section 2 of this Agreement, the CONTRACTOR shall maintain under contract, a Best Practice Network of providers including primary care physicians, medical sub specialists, tertiary pediatric centers/centers of excellence and dental providers specifically engaged to serve children in state custody as specified below.

3-1.2.1 Best Practice Network Primary Care Providers

- a. The CONTRACTOR shall maintain a Best Practice Network of Primary Care Providers (BPN-PCPs) who are community pediatricians and family practice physicians who agree to provide care timely and manage all health care including coordination of referrals for needed assessments or subspecialty care and serve as an advocate for children in custody to assure they get appropriate care. Specifically, BPN-PCPs must agree to:
1. Provide EPSDT screenings timely;
 2. Provide not only basic health care services, but also care coordination of all the health care services of children in custody;
 3. Refer to physical health and behavioral health professionals in the Best Practice Network for specialty care; refer to the Tertiary Pediatric Center/Center of Excellence for Children in, or at risk, of state custody, Community Mental Health Center and Behavioral Health Referral Center when indicated; coordinate referrals when indicated with MCO/BHO;
 4. Request telephone consultations with BHRC when indicated;
 5. Communicate with caregivers on plan of care;
 6. Maintain all health information on children assigned to them, regardless of who provides the care (Behavioral Health Referral Center, Tertiary Pediatric Center/Center of Excellence for children in, or at risk of, state custody, local specialist, behavioral health provider, other health care providers);
 7. Report to DCS Health Unit any time health information on a child is not forwarded in a timely manner to allow for appropriate evaluation and care;
 8. Forward medical files to newly assigned PCP and provide an initial consult when child is being transferred to a new geographical area or new MCO;
 9. Share health information with DCS and foster parents within confidentiality guidelines;
 10. Forward pertinent information to providers seeing child on referral
 11. Utilize (and document usage) of Best Practice Guidelines for care when developed and adopted by the Steering Panel and Executive Oversight Committee. Document rationale for variation from Best Practice guidelines;
 12. Review information provided by state or MCO/BHO on caring for children in State custody;
 13. Participate in the evaluation of system and outcomes through representation on the CSHN Steering Panel;
 14. Participate in the MCO/BHO selected for children in custody;
 15. Participate in training related to health problems of children in custody or Best Practice Guidelines; and
 16. Develop health treatment plans and incorporate all treatment needs of the children they see.
- b. The BPN-PCPs must also agree to perform the following case management functions:
1. Maintenance of all health information on children including behavioral health'
 2. Coordinate health services and request assistance from DCS case manager in following up and assuring plan of care is implemented;.
 3. Consult with the Behavioral Health Referral Center or other behavioral health providers when additional help is needed in managing a case; and
 4. Notify DCS when he/she feels more intense case management is needed by DCS.
- c. For the first ninety days after the effective date of this Agreement, if a BPN-PCP is not available, a provider who is willing to be a PCP for children in custody that is not in the Best Practice Network may serve as the child's PCP.

- d. After the first ninety days after the effective date of this Agreement, the CONTRACTOR must insure that each DCS custody child is assigned to a Best Practice Network Primary Care Provider within thirty days of enrollment. However, if a child has an established relationship with a provider who is not in the Best Practice Network, but is willing to continue care for this child and is qualified and competent to provide the care, the CONTRACTOR will allow the PCP to continue to provide care and reimburse the provider for care at the same rate as Best Practice Network Providers, if requested by DCS or the child's legal guardian.
- e. The CONTRACTOR may penalize BPN-PCPs who do not comply with the required responsibilities specified in paragraph 3.1.2.3.a above. Any penalty to be assessed must be described in writing in the BPN-PCP's provider agreement and must be approved by the State.
- f. When the State develops an internet based system for health providers to utilize for children in state custody, the CONTRACTOR shall assist with provider education efforts on the system and amend its BPN-PCP Agreements to require BPN-PCPs to input required information into the system.

3-1.2.2 Best Practice Network Dental Providers

- a. The CONTRACTOR shall maintain a Best Practice Network of Dental providers who will provide screenings to children in or at prolonged risk of state custody over three years of age and also provide any care that is needed within their scope of practice and competency.
- b. Whenever the dental network is inadequate and dental care is urgent, the CONTRACTOR shall arrange for an out-of-network provider to provide care.

3-1.2.3 Tertiary Pediatric Centers (Center of Excellence for Children in or Risk of State Custody)

The CONTRACTOR shall maintain contracts with all sites in the state recognized as tertiary pediatric care centers for pediatric care: Johnson City, Knoxville, Chattanooga, Nashville and Memphis. The CONTRACTOR shall maintain contracts with each of these centers specifically for the provision of services to children in and at risk of state custody.

3-1.2.4 Pediatric Sub-Specialists

The CONTRACTOR shall establish and maintain a network of pediatric sub-specialists in each of the five catchment areas in the state (Johnson City, Knoxville, Chattanooga, Nashville and Memphis) that includes each type of pediatric sub-specialist with admitting privileges at the catchment area tertiary pediatric center.

3-1.3 Safety-Net

- a. EPSDT – Physical Health Screenings. For the first ninety (90) days, the Local Health Departments shall serve as safety net providers until the Best Practice Network is fully developed. The CONTRACTOR may also elect to reimburse an out-of-network provider at the enhanced EPSDT payment rate for Best Practice Network Primary Care Physicians until the network is fully developed, as specified in Section 3.1.2.1.c. A penalty of \$1000 per occurrence shall be assessed whenever an initial EPSDT screening can not be provided within 21 days of enrollment and the CONTRACTOR received timely notification that the child was in state custody.
- b. EPSDT – Dental Screenings. Local Health Departments, in which dental services are available, will provide safety net services. As specified in Section 5, an enhanced EPSDT dental screening

rate will be paid to the local health departments as well as any Best Practice network dentists. Whenever the dental network is inadequate and dental care is urgent, the CONTRACTOR shall arrange for an out-of-network provider to provide the care.

3-1.4 Provider Agreement Language

The CONTRACTOR shall include in its subcontracts and agreements with providers a provision which states that subcontractors and providers are not permitted to encourage or suggest, in writing or verbally, that TennCare children be placed into state custody in order to receive medical or behavioral services covered by TennCare.

3-1.5 Network Management

- a. Provider Education. The CONTRACTOR shall train the Best Practice Network on the roles and responsibilities of Best Practice Network Providers, including the requirement to use Best Practice Guidelines and maintain complete medical records, in accordance with the requirements listed at 3-1.2.1.
- b. Monitoring. The CONTRACTOR shall conduct a medical chart review two times over the course of this Agreement of a statistically valid sample of each BPN provider's medical charts to document Best Practice Network provider compliance with the requirements of the Revised Remedial Plan, including the use of Best Practice Guidelines and completion of all seven required components of initial EPSDT exams (or documentation explaining any reasons for not adhering to the guidelines or completing the seven components of the exam). The sampling methodology employed must be approved by TennCare prior to use.
- c. Provider Profiling. The CONTRACTOR shall profile BPN-PCPs. Provider profiling for the Best Practice Network shall include the activities specified at 2-9.4.

3-1.6 BPN Training

The CONTRACTOR shall require Best Practice Network provider participation in training sessions provided by the Tertiary Pediatric Center/Center of Excellence or Behavioral Health Referral Center and disseminate training materials to Best Practice Network providers as requested. Participation in training may be by teleconference, interactive Internet program, or in-person. In the event the provider is unable to participate in training, the CONTRACTOR shall require the provider to submit a written attestation that training materials have been reviewed.

3-1.7 Service Delivery Requirements

In addition to satisfying the requirements of Section 2 of this Agreement for the delivery of services, the CONTRACTOR shall meet the following requirements for the delivery of services to children in state custody:

- a. Access and Availability of Services. The CONTRACTOR shall maintain a network with a sufficient number of Best Practice Network PCPs to consistently meet the timeline of:
 1. scheduling EPSDT screenings for children in state custody within 3 days of the child's placement in state custody; and
 2. completing EPSDT screenings within 21 days of enrollment in the CONTRACTOR's plan.

- b. Failure to Maintain Adequate Capacity in Network and Recruitment of Best Practice Network Providers. The CONTRACTOR shall recruit Best Practice Network providers who have appropriate credentials, are willing to follow BPN guidelines and are willing to participate in its network. DCS will report any incidences where providers are not available to deliver services within the time frames specified for EPSDT screenings or within the time frames specified as needed by the Best Practice Network Provider or BHRC to the Health Services Team and TennCare. The HST will keep records and report to the Executive Oversight Committee in what areas of the state an inadequate network exists. The CONTRACTOR will be notified when reports indicate a network deficiency and when recruitment of additional providers is necessary. When the Health Services Team identifies that a network is inadequate (in a geographic or in a specialty) and the HST has identified a qualified provider available and willing to participate in the network, the CONTRACTOR must contract with that willing provider or demonstrate to the satisfaction of the Health Services Team that their network is adequate according to above criteria.
- c. Mental Health and Substance Abuse Services. The MCO/BHO coordination agreement shall specify requirements to support the coordination of mental health and substance abuse services for children in state custody in accordance with the following requirements:
1. Neither the CONTRACTOR nor the BHO shall limit the types or number of behavioral services that may be provided by a Best Practice Network Primary Care Provider.
 2. The CONTRACTOR shall not make payment for services provided by Best Practice Network Primary Care Providers with an ICD-9 diagnosis code in the range 290.xx – 320.xx. It is the responsibility of the CONTRACTOR to notify BPN-PCPs to submit all such services to the BHO for reimbursement.
 3. Prior approval shall not be required by the CONTRACTOR or the BHO in order for a Best Practice Network Primary Care Provider to refer children in state custody to a BHO Best Practice Network Provider.
 4. The CONTRACTOR shall provide a listing of credentialed BPN-PCPs to the BHO on a monthly basis to facilitate BHO payment authorization.
- d. Service Authorization. When a covered service has been requested by a health care provider for a child in or at risk of state custody, and the CONTRACTOR denies or otherwise fails timely to provide that service or approve a less intense service which the provider or DCS feels is inadequate, the Health Services Team (HST) will be contacted for disposition:
1. If the HST, in consult with the provider and MCO, determines that the approved service is adequate then no change will be made. (If the service fails in the judgment of the DCS staff, the HST member can be contacted for a reassessment of the situation)
 2. If the HST agrees with the MCO that the ordered service is not appropriate for the child, but the provider maintains that the ordered service is necessary, then the HST shall advise the provider of appeals rights on behalf of enrollee.
 3. If the HST agrees with the provider that a more intense service is needed, the HST will issue a letter of authorization and file an appeal. Where practicable, the HST will utilize a qualified provider in the CONTRACTOR's network. However, a network provider will not be utilized if the Health Services Team, in the exercise of its sole discretion determines any of the following:
 - i. There is no time to locate a network provider under the circumstances.
 - ii. A network provider is not available to provide the services in a timely fashion,
 - iii. Available network providers are not qualified to deliver needed services, or
 - iv. Utilizing a network provider would otherwise jeopardize the health of the child in

need of services

4. Whenever the HST authorizes the services under this provision, the CONTRACTOR shall reimburse the provider for ordered service. In this situation the CONTRACTOR shall not require credentialing of the provider or an onsite visit in order for reimbursement to occur.

e. Services While Transitioning Out of Custody. Children transitioning out of custody, shall continue to have access to Best Practice Network providers for a minimum period of six months. The child transitioning out of state custody will remain in the CONTRACTOR's plan and the CONTRACTOR will continue to provide services in accordance with the Revised Remedial Plan requirements unless the child's legal guardian elects for the child to receive services outside of the best practice network. All requirements for "children in state custody" in this Agreement are applicable to children transitioning out of state custody for a minimum of six months.

When a child goes home for a 90-day trial but is still in custody, this will count for the first three months of transition time. The above services can also be continued for an additional six months on a case by case basis for a total of 365 days from the time of custody termination for those children whom DCS or the PCP and the Health Services Team deem it appropriate to prevent them from returning to state custody.

f. Children at Prolonged Risk of State Custody. Children that are deemed to be at prolonged risk of custody (to be defined by the Steering Panel) and that are identified to the CONTRACTOR by the state may continue to receive services through the Best Practice Network indefinitely.

3-1.8 Reporting Requirements

After the initial assignment of children in state custody to TennCare Select, the CONTRACTOR shall submit to the State a report that identifies the name of each DCS child enrolled in TennCare Select, the child's ID number, the date the child was placed in state custody, the date the CONTRACTOR received notice of enrollment, and the date of the child's initial EPSDT exam, updated on a monthly basis.

3-1.9 Performance Guarantees

Beginning September 1, 2001, the CONTRACTOR agrees to be bound by the performance guarantees identified below for the duration of this Agreement.

a. Timeliness of Care

1. Initial EPSDT exams completed within 21 days of placement in custody, when the following occurs: (1) timely notification of enrollment (within 48 hours), and (2) DCS has scheduled appointment within three (3) days of placement in custody

Penalty for Non-compliance:	\$1000 per occurrence
Measurement:	DCS notification and encounter data

b. EPSDT

A 100% EPSDT screening compliance rate including all seven components, unless reasons for missing components are appropriately documented

Penalty for Non-compliance:	\$500 per child with an incomplete or missing EPSDT exam
Measurement:	Medical record review

c. Provider Training Participation

BPN provider training participation at least once a year by teleconference, interactive internet program or in-person, unless written attestation that training materials have been reviewed is obtained, as specified at Section 3-1.6

Penalty for Non-compliance: \$100 per participating BPN-PCP that does not attend per training session

Measurement: Attendance Records and Written Attestations

d. Timely Completion of Best Practice Guidelines

In accordance with the priorities specified by the Steering Panel, the CONTRACTOR shall work with the Best Practice Guidelines Subcommittee of the Steering Panel to draft four Best Practice Guidelines per year, as specified at Section 3-1.e.

Penalty for Non-compliance: \$10,000 per missing submission, or submissions received after the due date agreed to with the Subcommittee

Measurement: Completed Guideline

3-2 Department of Children's Services Responsibilities

The Department of Children's Services shall be responsible for the following:

- a. Maintain responsibility of seeing that children in custody receive appropriate health services, including arranging the appointments for screenings. Report on number of children receiving EPSDT screenings in timely fashion.
- a. Provide care coordination and case management consistent with the *John B* Consent Decree and Medicaid regulations.
- b. Provide a representative to the CSHN Steering Panel.
- c. The Commissioner will participate as a member in the Executive Oversight Committee.
- d. For services provided through DCS, assure that these services are provided with reasonable promptness to meet individual needs.
- e. Amend its provider contracts/policy manuals to include a provision which states that DCS contracted entities are forbidden from encouraging or suggesting, in writing and verbally, that TennCare children be placed into state custody to receive medical or behavioral treatments. Instead they are to make caregivers aware of the alternative option and how they can contact the Health Services Team for assistance in getting behavioral health service.
- f. Expand contracts with mental health professionals working with Health Units to have at least one full time equivalent per region.

- g. Track children in custody in order to determine recidivism; relate to length of time of the transition period and what services were provided. Provide information on children who receive services to prevent custody and the outcome of such services.
- h. Provide training to staff to carry out the components of this plan.
- i. Continue process with the Working Group of the Steering Panel to determine support systems needed by DCS case managers to enhance their ability to better serve children with Severe Emotional Disturbances.

3-3 TennCare Bureau Responsibilities

The TennCare Bureau shall be responsible for the following:

- a. Contract with one MCO (accomplished by this contract) and one BHO, each with a statewide network that has expertise for children's physical, developmental and behavioral problems to provide care management services to children in custody and children at "prolonged risk" of custody (to be defined by the Steering Panel) using fee for service structure and an arrangement which decreases the financial risk for the MCO and BHO.
- b. Establish the mechanism to cover capital expenditures for dental operations in local health departments with the capability to establish or expand dental services, and arrange with the MCO to pay health departments according to an agreed upon fee schedule; arrange for private providers to receive the same enhanced EPSDT screening rate as health departments.
- c. Develop a mechanism to underwrite the costs for supplemental behavioral health staff, if necessary for recruitment, to be placed in communities and a plan for evaluating the effectiveness of this strategy.
- d. Contract with the COE/BHRC for any services needed to implement this plan (for child psychiatrist, training, other functions as negotiated)
- e. Fund any part of needs assessment felt to be required by the CSHN Steering Panel and the Executive Oversight Committee.
- f. Require MCO and BHO to provide adequate encounter and financial data to determine the provided services and the cost of those services for children in custody.
- g. Provide resources for staffing the CSHN Steering Panel and Health Services Team.
- h. Participate on the CSHN Steering Panel and the Executive Oversight Committee (the latter representative must be either the Director of TennCare or his supervising official in the Department of Finance and Administration).
- i. Require the MCO/BHO to include in its subcontracts with providers a provision which states that the subcontractors are forbidden from encouraging or suggesting, in writing or verbally, TennCare children be placed into state custody to receive medical or behavioral treatments. But instead, they are to let families know that there are other options and refer them to the Health Services Team when they are unable to get behavioral health services and are at risk of coming into custody.
- j. Arrange with BHO for custody children to have advantage of Continuous Treatment Teams when determined to be needed to maintain the child in the home.

- k. Develop a process whereby children who are already enrolled in TennCare but may not be assigned to the custodial MCO/BHO will be reassigned as soon as TennCare has been informed that the child is in state custody or is at risk of state custody and should be placed in the custodial MCO/BHO.

3-4 Health Services Team

The Health Services Team shall:

- a. Review MCO and BHO denials or delays for services and issue letter of authorization for those services it determines to be appropriate under the circumstances.
- b. The Health Services Team is expressly granted access to the medical records (physical and behavioral) of those children the Health Services Team is required to assist in accordance with the Revised Remedial Plan . All of the medical records obtained by the Health Services Team shall be held in the strictest confidence, and shall not be released to any individual unless the requesting individual is expressly granted such access by law, or unless the Health Services Team is ordered to release them by a court of component jurisdiction.
- c. Determine when children referred to them are at imminent risk of custody and need additional services provided to this group to prevent custody. (DCS will still perform this service also.)
- d. Act as ombudsmen for children in custody or at risk of custody by working with providers, DCS, agencies serving children, and courts to get consensus on what is best for the child and the family, to assist in getting that services approved by the BHO or DCS.
- e. Identify areas where provider networks are inadequate from the problems the team experiences in obtaining services for children at risk of custody as well as those in custody. Recommend to MCOs and BHOs (both for the custody children and the other children in TennCare) where networks are inadequate. Recommend to MCOs and BHOs qualified providers willing to contract with the network.
- f. Staff the Steering Panel as well as the Executive Oversight Committee.
- g. Assist in negotiations for contracts needed to implement the Revised Remedial Plan.

4 ENROLLMENT AND DISENROLLMENT

The TennCare Bureau has identified groups of enrollees who may become members of TennCare Select. TennCare enrollees cannot request to enroll in TennCare Select. Eligibility determination and enrollment of TennCare eligible enrollees in the Contractor's plan shall be the sole responsibility of TENNCARE.

4-1 Enrollment

4-1.1 General Provisions

- a. The State shall select TennCare eligibles to be enrolled in TennCare Select. TennCare eligibles shall not be enrolled in TennCare Select with an effective date prior to July 1, 2001. The following TennCare eligibles may be enrolled:
- | | |
|-------------------|--|
| Group 1.A: | Children who are in DCS custody; |
| Group 1.B: | Children who are transitioning out of DCS custody; |
| Group 2: | Children under 21 who are SSI eligible; |
| Group 3: | Children receiving services in an institution or as part of the State's Home and Community Based Service waiver in order to avoid being institutionalized; |
| Group 4: | Enrollees residing out-of-state; |
| Group 5: | Enrollees that have been responded to TennCare's attempts to contact; and |
| Group 6: | Enrollees residing in areas with insufficient capacity in TennCare risk MCOs |
- b. TennCare eligible enrollees in groups 1 through 5 will be enrolled in the CONTRACTOR's plan, independent of other TennCare eligible enrollees in the same household.
- c. To the extent possible, TENNCARE shall enroll all enrollees in Group 6 in the same household in the CONTRACTOR's plan.
- d. The CONTRACTOR agrees to accept TennCare eligibles other than those identified above upon receipt of notification from TENNCARE. The CONTRACTOR agrees to accept an administrative fee of \$13.84 per member per month for the period July 1, 2001 through June 30, 2002 and \$14.39 per member per month for the period July 1, 2002 through December 31, 2002 for these enrollees. However, should the State elect to carve out a high-risk TennCare eligible group(s), the administrative fee(s) associated with the group(s) will be mutually agreed upon between the CONTRACTOR and the State prior to enrollment of this population in the CONTRACTOR's plan.
- e. The CONTRACTOR shall accept daily eligibility data from the State.
- f. The CONTRACTOR agrees to accept a reasonable number of enrollees who have been selected by the State for enrollment, from any failed health plan in the CONTRACTOR's service area as well as any plan which is terminated in whole or in part, may become insolvent or discontinues service, or who reside in an area in which there is insufficient capacity in risk MCOs to enroll the population.

To the extent possible and practical, TENNCARE shall provide advance notice to the CONTRACTOR of the impending failure of one of the plans serving the area; however, failure by TENNCARE to provide advance notice shall not limit in any manner the responsibility of the CONTRACTOR to accept enrollees from failed risk MCOs. In the event the number of re-assigned enrollees exceeds 100,000 and TENNCARE was unable to provide ninety (90) days advance notice to the CONTRACTOR, TENNCARE will afford the CONTRACTOR a 90-day period of time to adjust operational processes in order to meet the contractual performance requirements prior to assessing any penalties against the CONTRACTOR. TennCare and the

Contractor recognize that large increases and decreases in enrollment may be required by program needs. TENNCARE shall provide 120 days advance notice of any planned transfer of enrollees out of the Contractor's plan that would result in a decrease of 100,000 members or more. The preceding statement is not intended to provide advance notice of changes that occur during the course of an open enrollment period or that are due to an enrollee's choice.

- g. No enrollee from another health plan shall be transferred retroactively to the CONTRACTOR's plan, except as specified at 4-1.1.n.
- h. The CONTRACTOR shall accept the enrollee in the health condition the enrollee is in at the time of enrollment.
- i. With the exception of enrollees in Group 4, TENNCARE shall enroll only persons who reside within the community service area(s) in which the CONTRACTOR is authorized to serve.
- j. The CONTRACTOR shall continue to be responsible for the care of any enrollee enrolled in TennCare Select until such time as the enrollee selects or is assigned to a TENNCARE plan in the area where the enrollee has moved, or assigned to another TENNCARE product administered by the CONTRACTOR, or has been disenrolled from the MCO by TENNCARE and re-enrolled in a new MCO. TENNCARE shall continue administrative fee payments and medical service payments, in accordance with Section 5, to the CONTRACTOR on behalf of the enrollee until such time as the enrollee is enrolled in another MCO plan. The CONTRACTOR shall remain responsible for arranging for the provision of services and payment of medical services for the enrollee until such time as the enrollee is enrolled in another plan. TENNCARE shall notify the CONTRACTOR promptly upon enrollment of the enrollee in another plan.
- k. Enrollment shall begin at 12:01 a.m. on the effective date that the enrollee is enrolled in the CONTRACTOR's plan and shall end at 12:00 midnight on the date that the enrollee is disenrolled pursuant to the criteria in TennCare policy and/or TennCare rules and regulations. Women who are determined presumptively eligible are given immediate TennCare eligibility and a temporary identification form to confirm eligibility pending the issuance of a regular identification card by their selected MCO. The purpose of this temporary identification/eligibility confirmation form is to enable the women to access prenatal care at the earliest possible time. The CONTRACTOR shall be responsible for arranging for the provision of services and payment of all covered services during the period of enrollment.
- l. Enrollees selected for enrollment in the CONTRACTOR's plan by the State in Groups 1, 2, 3, 5 and 6 shall have one (1) opportunity, anytime during the ninety (90) day period immediately following enrollment, to request to change MCO plans. Enrollees in Group 6 shall only be able to request to change MCO plans during this period to the extent capacity is available in another MCO serving the region. Once the initial ninety-day change period has expired, the enrollee shall remain a member of the CONTRACTOR's plan until the following change period, or until the enrollee loses eligibility for TennCare.
- m. TennCare shall provide an opportunity for enrollees to choose a new MCO during an annual choice period that shall be determined by TENNCARE. The effective date of any changes resulting from said choice period shall be January 1 of the following year, unless otherwise specified by TENNCARE. TENNCARE shall notify the CONTRACTOR of timeframes for authorized choice periods.
- n. It is the intent and policy of TENNCARE that TennCare-eligible newborn children and their TennCare eligible mothers, be enrolled in the same MCO. This policy is only applicable to Group 6 enrollees. Enrollment of the newborn child in the same plan as its Mother facilitates coverage and payment of the costs associated with delivery, facilitates coverage and payment of the newborn services provided after birth of the child but prior to establishment of individual TennCare eligibility for the child and provides a financial incentive to the CONTRACTOR to

promote prenatal care as a means to reduce the risks of a complicated and more costly pregnancy and/or delivery.

It is recognized by TENNCARE and the CONTRACTOR that despite the best efforts of TENNCARE to assure enrollment of a newborn in the same plan as its Mother, due to the various means of enrollment in the TennCare program, a newborn child may be inadvertently enrolled in a plan different than its Mother. When such cases are identified by the CONTRACTOR, the CONTRACTOR shall immediately report to TENNCARE, in accordance with written procedures provided by TENNCARE, that a newborn child has been incorrectly enrolled in a plan different than its Mother. Upon receipt of such notice from a CONTRACTOR or discovery by TENNCARE that a newborn has been incorrectly enrolled in a plan different than its Mother, TENNCARE shall immediately:

- (1) Disenroll the newborn from the incorrect plan;
- (2) Recoup any payments made to the CONTRACTOR for the newborn;
- (3) Enroll the newborn in the same plan as its Mother with the same effective date as when the newborn child was enrolled in the incorrect plan; and
- (4) Make payments to the correct plan for the period of coverage.

The plan in which the newborn child is correctly enrolled shall be responsible for the coverage and payment of TennCare-covered services provided to the newborn child for the full period of eligibility. The plan in which the newborn child was incorrectly enrolled shall have no liability for the coverage or payment of any TennCare-covered services provided, except as described below, during the period of incorrect plan assignment and TENNCARE shall have no liability for payments to the CONTRACTOR in these cases.

There are circumstances in which a newborn child's Mother may not be eligible for participation in the TennCare program. The CONTRACTOR shall be required to process claims received for services provided to newborn children within the time frames specified in Section 2-9.7 of this Agreement. The CONTRACTOR shall not utilize any blanket policy which results in the automatic denial of claims for services provided to a TennCare-eligible newborn child; during any period of enrollment in the CONTRACTOR's plan, because the child's Mother is not a member of the CONTRACTOR's plan. However, it is recognized that in complying with the claims processing time frames specified in Section 2-9.7 of this Agreement, the CONTRACTOR may make payment for services provided to a TennCare-eligible newborn child enrolled in the CONTRACTOR's plan at the time of payment but the child's eligibility may subsequently be moved to another contractor's plan. In such event, the CONTRACTOR in which the newborn child is first enrolled (first plan) may submit supporting documentation to the contractor's plan in which the newborn child is moved (second plan) and the second plan shall reimburse the first plan within thirty (30) days of receipt of such properly documented request for reimbursement, for the amount expended on behalf of the child prior to the child's eligibility having been moved to the second plan. Such reimbursement shall be the actual amount expended by the CONTRACTOR and shall be used to reduce the amount of funds requested from the State in the weekly remittance request. In the event the CONTRACTOR is the second plan (i.e. the plan to which the newborn child is moved), should the CONTRACTOR fail to reimburse the first plan the actual amount expended on behalf of the newborn child within thirty (30) days of receipt of a properly documented request for payment, TENNCARE is authorized to reimburse the first plan.

- o. The CONTRACTOR or anyone acting on its behalf shall not submit enrollment applications or choice ballots on behalf of TennCare eligibles.

4-1.2 Enrollment Procedure

The CONTRACTOR shall give a full written explanation of the MCO's plan to enrollees within thirty (30) calendar days after notification of their enrollment in the plan, including but not limited to a member

handbook and an identification card as described in Section 2-6.2 of this Agreement. In addition to the information described above, this written explanation shall, at a minimum, also include:

- (a) Effective date of enrollment;
- (b) Names, locations, telephone numbers, office hours and within ninety (90) days of Agreement execution, non-English languages spoken by current network providers (including primary care providers, specialists and hospitals) and identification of providers accepting new patients. These updates shall be maintained in accordance with Section 2-1.0 of this Agreement;
- (c) The CONTRACTOR shall provide all other information as required by HCFA.

4-1.3 Remedial Plan Provisions

- a. To decrease the likelihood of recidivism, the enrollment period for children in Group 1.A who are transitioning out of state custody shall be extended for at least six (6) months after the date that the child is removed from DCS custody. Children will be assigned to Group 1.B during this post-custody transition period and shall continue to receive Remedial Plan services including access to Best Practice Network providers. After the post-custody period of at least six months, children assigned to Group 1.B shall be moved as appropriate, to Groups 2-6 and shall remain a member of the new group until the following change period, or until the child loses eligibility for TennCare. At the option of the State, children deemed to be at "prolonged" risk of state custody may remain in Group 1.B or an on-going basis.
- b. The CONTRACTOR agrees to accept daily eligibility updates in the form and format specified by TennCare for the purpose of identifying children in state custody and children transitioning out of state custody. Until such time as an indicator for children in state custody and children transitioning out of state custody can be added to the daily eligibility updates received from TennCare, the CONTRACTOR agrees to accept and process any adhoc report mutually agreed upon by the CONTRACTOR and TennCare to facilitate timely identification of children in state custody or children transitioning out of state custody.

4-2 Disenrollment

TENNCARE is responsible for the disenrollment of enrollees from the CONTRACTOR's plan.

4-2.1 General Requirements

- a. With the exception of enrollees in Group 4, TENNCARE eligible enrollees shall be able to disenroll from TennCare Select and re-enroll in a risk-MCO during the annual choice period, subject to the capacity of risk-MCOs.
- b. TENNCARE may disenroll enrollees that were originally enrolled due to insufficient capacity in TENNCARE risk-MCOs (Group 6) at any time. However, TENNCARE shall provide 90 days advance notice prior to disenrollment of enrollees from the CONTRACTOR's plan and re-enrollment into a risk-MCO.
- c. No enrollee shall be disenrolled from a health plan for any of the following reasons:
 - 1. Adverse changes in the enrollee's health;
 - 2. Pre-existing medical conditions;
 - 3. High cost medical bills; or
 - 4. Failure or refusal to pay applicable cost-sharing fees, except when TENNCARE has approved such disenrollment.

4-2.2 Contractor's Responsibility for Disenrollments

The CONTRACTOR'S responsibility for disenrollment shall be to:

1. Inform each enrollee at the time of enrollment, of the criteria for disenrollment from the plan as permitted by TennCare policy and/or TennCare rules and regulations;
2. Inform TennCare promptly, in the manner and media described in Section 2-10.2 of this Agreement, when the CONTRACTOR knows or has reason to believe that an enrollee may satisfy any of the conditions for disenrollment described in TennCare policy and/or TennCare rules and regulations.

Actions taken by TennCare cannot be grieved by the CONTRACTOR.

5 PAYMENT TERMS AND CONDITIONS

5-1 Administrative Fee

The CONTRACTOR shall be paid a fixed fee per member per month for the administration of TennCare Select according to the requirements of this Agreement.

- a. The administrative fee to paid shall be:

Enrollee Category ¹	Effective July 1, 2001 - June 30, 2002	Effective July 1, 2002 - December 31, 2002
Group 1.A	\$21.84 PMPM	\$22.71 PMPM
Group 1.B	\$21.84 PMPM	\$22.71 PMPM
Group 2	\$21.84 PMPM	\$22.71 PMPM
Group 3	\$13.84 PMPM	\$14.39 PMPM
Group 4	\$13.84 PMPM	\$14.39 PMPM
Group 5	\$13.84 PMPM	\$14.39 PMPM
Group 6	\$13.84 PMPM	\$14.39 PMPM

- b. TennCare or its appointed agent shall make payment by the fifth working day of each month to the CONTRACTOR for the CONTRACTOR's satisfactory performance of its duties and responsibilities as set forth in this Agreement. Each month payment to the CONTRACTOR shall be equal to the number of enrollees certified by TENNCARE multiplied by the administrative fee for the appropriate enrollee category. The actual amount owed the CONTRACTOR for each enrollee shall be determined by dividing the appropriate monthly administrative fee by the number of days in the month and then multiplying the quotient of this transaction by the actual number of days the enrollee was enrolled in the plan.
- c. Payment for enrollees shall start the effective date of the enrollee's enrollment in the plan.
- d. The CONTRACTOR agrees the State may retroactively recoup Administrative Fee payments for deceased enrollees. Retroactive recoupment will be deducted from the monthly payment for the following month. Payments may be recouped back to the date of death. This is the only provision whereby the State may retroactively recoup administrative fee payments from the CONTRACTOR for enrollees retroactively terminated from TennCare Select.

5-2 Provider Reimbursement Rates

5-2.1 General Requirements

- a. Maximum Allowable Rates. Providers shall be paid according to BlueCare policies and procedures and reimbursement rates in effect as of March 1, 2001, unless otherwise directed by TennCare with the following exceptions:
1. The payment rate for an initial EPSDT screening conducted by a Best Practice Network Primary Care Provider for a child in state custody shall be at the rate specified in Section 5.2.2.a.

¹ As defined at 5.1.1.a.

2. The payment rate for preventive dental services provided by a Best Practice Network Dental Provider on a child in state custody shall be at the rate specified in Section 5.2.2.b.
 3. The payment rate for all other preventive health services specified in Attachment 5.1 for children (under age 21) may be increased up to 85% of the 2001 Medicare fee-schedule.
 4. The payment rate for all services that are reimbursed as a percentage of average wholesale prices shall be adjusted with fluctuations in the average wholesale price. However, the "percentage" applied to determine the payment amount shall be equivalent to the percentage applied for BlueCare as of March 1, 2001.
 5. The initial utilization management and referral processes and requirements impacting provider reimbursement shall be those in effect for BlueCare and TennCare Select as of July 1, 2001 as specified in Attachment II. However, the State may reserves the right to require the CONTRACTOR to modify these processes and requirements. The CONTRACTOR shall have sixty (60) days from the date of request to implement requested modifications.
 6. If there is a network deficiency that necessitates additional funding to remedy, the CONTRACTOR shall attempt to negotiate a reasonable rate on behalf of the State prior to recommending an increase in reimbursement rates. Once the negotiations are concluded, the CONTRACTOR shall submit a recommendation to the State in writing with supporting documentation justifying an increase in reimbursement rates. The CONTRACTOR may not implement a recommended change until receipt of written approval from TennCare.
- b. Annual Review. The maximum allowable reimbursement rates shall be reviewed on an annual basis.

5-2.2 Best Practice Network Requirements

- a. Enhanced Initial EPSDT Screening Rate. The CONTRACTOR shall make an enhanced payment to Best Practice Network Primary Care Providers for the initial EPSDT examination for children in state custody, when all seven (7) components of the exam have been completed. The seven components shall include: (1) A comprehensive health and development history to include both physical and mental health; (2) Comprehensive unclothed physical exam; (3) Appropriate vision and hearing assessment; (4) Laboratory testes appropriate for age and risk; (5) Dental screening and referral beginning at age 3; (6) Immunizations; (7) Health education (anticipatory guidance).
1. The procedure codes to be utilized when billing for the initial EPSDT exam are specified below. This language does not preclude the BPN-PCP from billing for other services separately, consistent with the CONTRACTOR's procedures for claims processing (e.g., lab). It is the responsibility of the CONTRACTOR to include in its Best Practice Network provider agreements a requirement that all seven components of the EPSDT exam are completed when an enhanced payment is made through a medical chart review. The CONTRACTOR should educate providers to document any barriers to completing all seven components (e.g. past history not available). The enhanced payment rate for the initial EPSDT screening exam shall be ninety-five percent (95%) of the 2001 Medicare fee-schedule.

NEW PATIENT	ESTABLISHED PATIENT
99431 – History and Examination of Normal Newborn	99391 – Periodic reevaluation
99381 – Initial evaluation	99392 – age 1 through 4 years
99382 – age 1 through 4 years	99393 – age 5 through 11 years
99383 – age 5 through 11 years	99394 – age 12 through 17 years

99384 – age 12 through 17 years	99395 – age 18 through 39 years
99385 – age 18 through 39 years	

If the BPN-PCP submits a claim with a procedure code for an established patient, the CONTRACTOR may only reimburse the provider at the enhanced payment rate if the claim is for the initial EPSDT exam upon placement in state custody. If the CONTRACTOR directs BPN-PCPs to only bill the initial EPSDT exam with the New Patient procedure code series identified above, the CONTRACTOR must notify and provide appropriate training to the provider and provider's billing staff to implement this billing procedure.

2. The CONTRACTOR shall conduct a medical chart review two times over the course of this Agreement of a statistically valid sample of each BPN-PCPs medical charts to ensure completion of all seven components of the initial EPSDT exam. The sampling methodology employed must be approved by TennCare prior to use. The CONTRACTOR shall recoup an amount equivalent to the difference between the enhanced EPSDT screening payment rate (95% of Medicare) and the standard EPSDT screening payment rate (85% of Medicare), if it is determined upon medical chart review that the provider to whom payment was made failed to complete all seven components of the exam.

- b. Enhanced Dental Fee-Schedule. The CONTRACTOR shall make an enhanced payment to Best Practice Network Dental Providers for children in state custody for preventive dental services, as specified below.

D0120 – Periodic Oral Evaluation	\$17.85
D0150 – Comprehensive Oral Evaluation	\$17.85
D1110 – Prophylaxis, children greater than 12 and less than 21 years of age	\$33.15
D1120 – Prophylaxis, Child	\$23.80
D1351 – Sealant, Per Tooth	\$19.55
D1203 – Fluoride, Child	\$17.85

- c. Case Management. In exchange for performing additional care coordination and case management functions as specified in Section 3 of this Agreement, the CONTRACTOR shall pay Best Practice Network Primary Care Providers a case management fee of \$10 per member per month.

5-3 Medical Services Payments

- a. Medical Services Payments. The CONTRACTOR shall prepare checks for payment on a periodic basis. The CONTRACTOR shall notify the State of the amount to be paid in a mutually acceptable form and substance at least 48 hours in advance of distribution of provider checks. The amount to be paid shall be reduced by the amount of third party recoveries captured in the claims processing system. The State shall release funds in the amount to be paid to providers to the CONTRACTOR. Funds shall be released within 48 hours of receipt of notice.
- b. 1099 Preparation. The CONTRACTOR shall prepare and submit 1099 Internal Revenue Service reports for all providers to whom payment is made.
- c. Interest. Interest generated from the deposit of funds for provider payments shall be the property of the State. The amount of interest earned on the funds, as reported by the CONTRACTOR's

bank on the monthly statement, shall be deducted from the amount of the next remittance request subsequent to receipt of the bank statement.

- d. Pharmacy Rebates. The amount of pharmacy rebates collected by the CONTRACTOR for TennCare Select enrollees shall be the property of the State. On a quarterly basis, the CONTRACTOR shall notify the State and provide supporting documentation of the value of said rebates. The first claims payment remittance request following the receipt of rebates will be reduced by the value of the rebates reported.
- e. Subrogation Recoveries. The amount of any subrogation recoveries collected by the CONTRACTOR outside of the claims processing system shall be the property of the State. On a monthly basis, the CONTRACTOR shall report to the State the amount of any subrogation recoveries collected outside the claims processing system received during the previous month. The next remittance request subsequent to this monthly report shall be reduced by the value of the subrogation recoveries reported.
- f. HMO Payment. Payments to the CONTRACTOR shall be increased sufficiently to cover any additional amount due pursuant to Tennessee Code Annotated Section 56-32-224 thirty days after the end of each calendar year quarter. In the event the amount due pursuant to TCA 56-32-224 is increased during the term of this Agreement, the payments to the CONTRACTOR shall be increased by an amount equal to the increase in the amount due by the CONTRACTOR.

5-4 Payment Requirements

- a. Except where required by the Contractor's Agreement with TennCare or by applicable federal or state law, rule or regulation, the CONTRACTOR shall not make payment for the cost of any medical care provided prior to the effective date of eligibility in the CONTRACTOR's plan. The CONTRACTOR shall make payment for the cost of any covered services obtained on or after 12:01 a.m. on the effective date of eligibility in the CONTRACTOR's plan.
- b. The claims payment amount shall not include payment for enrollee cost-sharing amounts.
- c. The claims payment amount shall be net of any amounts that the provider is entitled to collect pursuant to applicable coordination of benefits rules.
- d. When eligibility has been established by TENNCARE and the enrollee has incurred medical expenses that are covered benefits within the plan, the CONTRACTOR shall make reimbursement for the medical services at the regular negotiated rate if the service was provided by a contract provider. If the service was provided by a non-contract provider, the CONTRACTOR shall assure that the enrollee is held harmless by the provider for the costs of the service or procedure except for applicable cost share amounts. The CONTRACTOR shall require, as a condition of payment, that the service provider accept the amount paid by the CONTRACTOR or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payor) plus any applicable amount of cost share amounts due from the enrollee as payment in full for the covered service.

5-5 Audits

- a. The CONTRACTOR shall allow for periodic review of records to ensure that all discounts, special pricing considerations and financial incentives have accrued to the State and that all costs incurred are in accordance with this Agreement. The CONTRACTOR shall provide the auditor access to all information necessary to perform the examination.

**ATTACHMENT 5.I
PREVENTIVE SERVICES FEE SCHEDULE**

The CONTRACTOR shall make an enhanced payment, defined as eighty-five percent (85%) of the 2001 Medicare fee-schedule or the BlueCare reimbursement rates in effect as of March 1, 2001, whichever is greater, to Primary Care Providers for the provision of the following preventive medical services identified by the CPT procedure codes listed below, when billed for children less than 21 years of age. Payment rates for services reimbursed as a percentage of average wholesale price shall be adjusted in accordance with Section 5.2.1.a.4. of this Agreement.

Office Visits

NEW PATIENT	ESTABLISHED PATIENT
99431 – History and Evaluation of Normal newborn	99391 – Periodic reevaluation
99381 – Initial evaluation	99392 – age 1 through 4 years
99382 – age 1 through 4 years	99393 – age 5 through 11 years
99383 – age 5 through 11 years	99394 – age 12 through 17 years
99384 – age 12 through 17 years	99395 – age 18 through 39 years
99385 – age 18 through 39 years	

Counseling and Risk Factor Reduction Intervention

INDIVIDUAL	GROUP
99401 – approximately 15 minutes	99411 – approximately 30 minutes
99402 – approximately 30 minutes	99412 – approximately 60 minutes
99403 – approximately 45 minutes	
99404 – approximately 60 minutes	

Other Preventive Services

99420	Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal)
90700 – 90744	Immunizations
92551	Screening test, pure tone, air only (Audiologic function)
92552	Pure tone audiometry (threshold); air only

6 TERMS AND CONDITIONS

6-1 *Applicable Laws and Regulations*

The CONTRACTOR agrees to comply with all applicable federal and state laws and regulations, and court orders, including Constitutional provisions regarding due process and equal protection of the laws and including but not limited to:

- a. Title 42 Code of Federal Regulations (CFR) Chapter IV, Subchapter C (with the exception of those parts waived under the TennCare Section 1115(a) waiver).
- b. Title 45 CFR, Part 74, General Grants Administration Requirements.
- c. Titles 4, 47, 56, and 71, Tennessee Code Annotated, including, but not limited to, the TennCare Drug Formulary Accountability Act, Public Chapter 276 and The Standardized Pharmacy Benefit Identification Card Act.
- d. All applicable standards, orders, or regulations issued pursuant to the Clean Air Act of 1970 as amended (42 U.S.C. 7401, et seq.).
- e. Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d) and regulations issued pursuant thereto, 45 C.F.R. Part 80.
- f. Title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e) in regard to employees or applicants for employment.
- g. Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 794, which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting from federal financial assistance, and regulations issued pursuant thereto, 45 C.F.R. Part 84.
- h. The Age Discrimination Act of 1975, as amended, 42 U.S.C. 6101 et seq., which prohibits discrimination on the basis of age in programs or activities receiving or benefiting from federal financial assistance.
- i. The Omnibus Budget Reconciliation Act of 1981, P.E. 97-35, which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefiting from federal financial assistance.
- j. Americans with Disabilities Act, 42 U.S.C. Section 12101 et seq., and regulations issued pursuant thereto, 28 C.F.R. Parts 35, 36.
- k. Sections 1128 and 1156 of the Social Security Act relating to exclusion of providers for fraudulent or abusive activities involving the Medicare and/or Medicaid program.
- l. Tennessee Consumer Protection Act, T.C.A. Section 47-18-101 et seq.
- m. The HCFA waiver and all Special Terms and Conditions which relate to the waiver.
- n. Executive Orders, including Executive Order 1 effective January 26, 1995.
- o. The Clinical Laboratory Improvement Act (CLIA) of 1988.
- p. Requests for approval of material modification as provided at TCA 56-32-201 etc .seq.

6-2 Termination

In the event of termination, it is agreed that neither party shall be relieved from any financial obligations each may owe to the other as a result of liabilities incurred during the course of this Agreement. For terminations pursuant to parts 6.2.1, 6.2.2, 6.2.3. or 6.2.5. TENNCARE will assume responsibility for informing all affected enrollees of the reasons for their termination from the plan.

6-2.1 Termination Under Mutual Agreement

Under mutual agreement, TENNCARE and the CONTRACTOR may terminate this Agreement for any reason if it is in the best interest of TENNCARE and the CONTRACTOR. Both parties will sign a notice of termination that shall include, inter alia, the date of termination, conditions of termination, and extent to which performance of work under this Agreement is terminated.

6-2.2 Termination by TENNCARE for Cause

a. The CONTRACTOR shall be deemed to have breached this Agreement if any of the following occurs:

- (1) The CONTRACTOR fails to perform in accordance with any term or provision of the Agreement;
- (2) The CONTRACTOR only renders partial performance of any term or provision of the Agreement; or
- (3) The CONTRACTOR engages in any act prohibited or restricted by the Agreement.

For purposes of Section 6-2.6, items (1) through (3) shall hereinafter be referred to as "Breach."

b. In the event of a Breach by the CONTRACTOR, TENNCARE shall have available any one or more of the following remedies in addition to or in lieu of any other remedies set out in this Agreement:

- (1) Recovery of actual damages, including incidental and consequential damages, and any other remedy available at law or equity;
- (2) Requirement that the CONTRACTOR prepare a plan to immediately correct cited deficiencies, unless some longer time is allowed by TENNCARE, and implement this correction plan;
- (3) Recover any and all liquidated damages provided in this Agreement;
- (4) Declare a partial default; and
- (5) Declare a default and terminate this Agreement.

In the event of a conflict between any other Agreement provisions and this provision, this provision shall control.

c. In the event of Breach by the CONTRACTOR, TENNCARE may provide the CONTRACTOR written notice of the Breach and twenty (20) calendar days to cure the Breach described in the notice. In the event that the CONTRACTOR fails to cure the Breach within the time period provided, then TENNCARE shall have available any and all remedies described herein and available at law.

d. In the event the CONTRACTOR disagrees with the determination of noncompliance or designated corrective action described in the notice, the CONTRACTOR shall nevertheless implement said corrective action, without prejudice to any rights the CONTRACTOR may have to later dispute the finding of noncompliance or designated corrective action.

e. Partial Default

(1) If the CONTRACTOR fails to cure the Breach within the time period provided in the cure Section above, then TENNCARE may declare a Partial Default and provide written notice to the CONTRACTOR of the following:

(a) The date upon which the CONTRACTOR shall terminate providing the service associated with the Breach; and

(b) The date TENNCARE or its designate will begin to provide the service associated with the Breach.

TENNCARE may revise the time period contained in the notice upon written notice to the CONTRACTOR.

(2) In the event TENNCARE declares a Partial Default, TENNCARE may withhold, together with any other damages associated with the breach, from the amounts due the CONTRACTOR the greater of:

(a) Amounts which would be paid the CONTRACTOR to provide the defaulted services; or

(b) the cost to TENNCARE of providing the defaulted service, whether said service is provided by TENNCARE or a third party; and

(3) To determine the amount the CONTRACTOR is being paid for any particular service, TENNCARE shall review all relevant documents and then make a final and binding determination of said amount.

6-2.3 Termination for Unavailability of Funds

In the event that federal and/or state funds to finance this Agreement become unavailable, TENNCARE may terminate the Agreement immediately in writing to the CONTRACTOR without penalty. The CONTRACTOR shall be entitled to receive and shall be limited to, just and equitable compensation for any satisfactory authorized work performed as of the termination date. Availability of funds shall be determined solely by TENNCARE.

6-2.4 Termination for CONTRACTOR Financial Inviability, Insolvency or Bankruptcy

If TENNCARE reasonably determines that the CONTRACTOR's financial condition under any TennCare Agreement is not sufficient to allow the CONTRACTOR to provide the services as described herein or under another TennCare Agreement in the manner required by TENNCARE, TENNCARE may terminate this Agreement in whole or in part, immediately or in stages. Said termination shall not be deemed a Breach by either party. The CONTRACTOR's financial condition shall be presumed not sufficient to allow the CONTRACTOR to provide the services described herein in the manner required by TENNCARE if the CONTRACTOR can not demonstrate to TENNCARE's satisfaction that the CONTRACTOR has risk reserves and a minimum net worth sufficient to meet the statutory standards for licensed health maintenance organizations.

CONTRACTOR insolvency or the filing of a petition in bankruptcy by or against the CONTRACTOR shall constitute grounds for termination for cause. In the event of the filing of a petition in bankruptcy by or

against a principal subcontractor or provider or the insolvency of said subcontractor or provider, the CONTRACTOR shall immediately advise TENNCARE.

6-2.5 Termination by TENNCARE for Convenience

TENNCARE may terminate this Agreement for convenience and without cause upon thirty (30) days written notice. Said termination shall not be a breach of contract by TENNCARE and TENNCARE shall not be responsible to the CONTRACTOR or any other party for any costs, expenses, or damages occasioned by said termination, i.e., without penalty.

6-2.6 Termination Procedures

The party initiating the termination shall render written notice of termination to the other party by Certified Mail, Return Receipt Requested, or in person with proof of delivery. The notice of termination shall specify the provision of this Agreement giving the right to terminate, the circumstances giving rise to termination, and the date on which such termination shall become effective.

Upon receipt of notice of termination, and subject to the provisions of Section 6-2.6, on the date and to the extent specified in the notice of termination and as directed by the State, the CONTRACTOR shall:

1. Stop work under the Agreement, but not before the termination date;
2. Terminate all marketing procedures and subcontracts or provider agreements relating to marketing;
3. At the point of termination, assign to TENNCARE in the manner and extent directed by TENNCARE all the rights, title and interest of the CONTRACTOR for the performance of the subcontracts to be determined at need in which case TENNCARE shall have the right, in its discretion, to settle or pay any of the claims arising out of the termination of such agreements and subcontracts;
4. Complete the performance of such part shall have not been terminated under the notice of termination;
5. Take such action as may be necessary, or as a contracting officer may direct, for the protection of property related to this Agreement which is in possession of the CONTRACTOR and in which TENNCARE has or may acquire an interest;
6. Continue to submit invoices for the payment of medical services as specified in Section 5. One hundred eighty days after the Agreement ends, the CONTRACTOR shall reasonably estimate the amount of claims remaining to be paid for medical services provided during the Agreement period that were not reflected in the final invoice. If TENNCARE accepts the estimate as reasonable, TENNCARE will deposit that amount in an account for the purpose of paying run-out claims. TennCare will supplement the funding of the account as necessary to permit coverage of the remaining payable claims as needed;
7. In the event the Agreement is terminated by TENNCARE, the CONTRACTOR shall continue to serve or arrange for provision of services to the enrollees in the plan for up to forty-five (45) calendar days from the Agreement termination date or until the enrollees can be transferred to another health plan, whichever is longer. During this transition period, TENNCARE shall continue to pay the applicable administrative fee, medical payments and HMO payments as specified in Section 5 of this Agreement;

8. The CONTRACTOR shall promptly make available to TENNCARE, or another health plan acting on behalf of TENNCARE, any and all records, whether medical or financial, related to the CONTRACTOR's activities undertaken pursuant to this Agreement. Such records shall be in a usable form and shall be provided at no expense to TENNCARE;
9. The CONTRACTOR shall promptly supply all information necessary to TENNCARE or another health plan acting on behalf of TENNCARE for reimbursement of any outstanding claims at the time of termination;
10. Submit a termination plan to TENNCARE for review, which is subject to TENNCARE approval. This plan must, at a minimum, contain the provisions in Sections 11. through 16. below. The CONTRACTOR shall agree to make revisions to the plan as necessary in order to obtain approval by TENNCARE. Failure to submit a termination plan and obtain approval of the termination plan by TENNCARE shall result in the withhold of 25% of the CONTRACTOR's monthly administrative fee payment as described in Section 5;
11. Agree to maintain claims processing functions as necessary for a minimum of nine (9) months (or longer if it is likely there are additional claims outstanding) in order to complete adjudication of all claims. During this period, medical payments and HMO payments shall continue to be paid as specified in Section 5
12. Agree to comply with all duties and/or obligations incurred prior to the actual termination date of the Agreement, including but not limited to, the appeal process as described in Section 2-8;
13. The CONTRACTOR shall file all reports concerning the CONTRACTOR's operations during the term of the Agreement in the manner described in this Agreement;
14. The CONTRACTOR shall take whatever other actions are necessary in order to ensure the efficient and orderly transition of participants from coverage under this Agreement to coverage under any new arrangement developed by TENNCARE;
15. Upon expiration or termination of this Agreement, the CONTRACTOR shall submit reports to TENNCARE every thirty (30) calendar days detailing the CONTRACTOR's progress in completing its continuing obligations under this Agreement. The CONTRACTOR, upon completion of these continuing obligations, shall submit a final report to TENNCARE describing how the CONTRACTOR has completed its continuing obligations. TENNCARE shall within twenty (20) calendar days of receipt of this report advise in writing whether TENNCARE agrees that the CONTRACTOR has fulfilled its continuing obligations. If TENNCARE finds that the final report does not evidence that the CONTRACTOR has fulfilled its continuing obligations, then TENNCARE shall require the CONTRACTOR to submit a revised final report. TENNCARE shall in writing notify the CONTRACTOR once the CONTRACTOR has submitted a revised final report evidencing to the satisfaction of TENNCARE that the CONTRACTOR has fulfilled its continuing obligations; and
16. In order for a terminated or partially terminated CONTRACTOR to resume providing terminated services, said terminated CONTRACTOR shall execute an entirely new application to participate in the TennCare program and shall execute a new Agreement.

6-3 Errors

The CONTRACTOR is expected to prepare carefully all reports for submission to TENNCARE. If after preparation and submission, a CONTRACTOR error is discovered either by the CONTRACTOR or

TENNCARE, the CONTRACTOR has fifteen (15) calendar days, where practical, after written notification to correct the error and submit accurate reports and/or invoices. Similarly, errors on TENNCARE's part identified by the CONTRACTOR shall be corrected within fifteen (15) calendar days, where practical, of receipt of written notification by the CONTRACTOR.

6-4 Use of Data

TENNCARE shall have unlimited but not exclusive rights to use, disclose, or duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by the CONTRACTOR resulting from this Agreement. However, TENNCARE shall not disclose proprietary information that is afforded confidential status by state or federal law.

6-5 Waiver

No covenant, condition, duty, obligation, or undertaking contained in or made a part of this Agreement may be waived except by written agreement of the Agreement signatories or in the event the signatory for a party is no longer empowered to sign such Agreement, the signatory's replacement, and forbearance, forgiveness, or indulgence in any other form or manner by either party in any regard whatsoever shall not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed, or discharged by the party to which the same may apply. Until complete performance or satisfaction of all such covenants, conditions, duties, obligations, or undertakings, the other party shall have the right to invoke any remedy available under law or equity notwithstanding any such forbearance, forgiveness or indulgence.

6-6 Agreement Variation

If any provision of this Agreement (including items incorporated by reference) is declared or found to be illegal, unenforceable, or void, then both TENNCARE and the CONTRACTOR shall be relieved of all obligation arising under such provisions. If the remainder of the Agreement is capable of performance, it shall not be affected by such declaration of finding and shall be fully performed. In addition, if the laws or regulations governing this Agreement should be amended or judicially interpreted as to render the fulfillment of the Agreement impossible or economically unfeasible, both TENNCARE and the CONTRACTOR will be discharged from further obligations created under the terms of the Agreement.

6-7 Conflict of Interest

The CONTRACTOR warrants that no part of the total Agreement amount provided herein shall be paid directly or indirectly to any officer or employee of the State of Tennessee as wages, compensation, or gifts in exchange for acting as officer, agent, employee, subcontractor, or consultant to the CONTRACTOR in connection with any work contemplated or performed relative to this Agreement unless otherwise authorized by the Commissioner, Tennessee Department of Finance and Administration.

This Agreement may be terminated by TENNCARE if it is determined that the CONTRACTOR, its agents or employees offered or gave gratuities of any kind to any officials or employees of the State of Tennessee. The CONTRACTOR certifies that no member of or delegate of Congress, the General Accounting Office, DHHS, HCFA or any other federal agency has or will benefit financially or materially from this Agreement.

The CONTRACTOR shall include the substance of this clause in all subcontracts and provider agreements.

6-8 Failure to Meet Agreement Requirements

It is acknowledged by TENNCARE and the CONTRACTOR that in the event of failure to meet the requirements provided in this Agreement and all documents incorporated herein, TENNCARE will be harmed. The actual damages that TENNCARE will sustain in the event of and by reason of such failure are uncertain and are extremely difficult and impractical to ascertain and determine. The parties therefore acknowledge that the CONTRACTOR shall be subject to damages and/or sanctions as described below. It is further agreed that the CONTRACTOR shall pay TENNCARE liquidated damages as directed by TENNCARE and not to exceed the fixed amount as stated below; provided however, that if it is finally determined that the CONTRACTOR would have been able to meet the Agreement requirements listed below but for TENNCARE's failure to perform as provided in this Agreement, the CONTRACTOR shall not be liable for damages resulting directly there from.

6-8.1 Intermediate Sanctions

TENNCARE may impose any or all of the sanctions as described in Section 6 upon TENNCARE's reasonable determination that the CONTRACTOR fails to comply with any corrective action plan (CAP) as described under Section 2-16 or is otherwise deficient in the performance of its obligations under the Agreement, provided, however, that TENNCARE only impose those sanctions it determines to be appropriate for the deficiencies identified. TENNCARE may impose intermediate sanctions on the CONTRACTOR simultaneously with the development and implementation of a corrective action plan if the deficiencies are severe or numerous.

Intermediate sanctions may include:

1. application of liquidated damages as described in Section 6-2;
2. suspension of enrollment in the CONTRACTOR's MCO as described in Section 2-16;
3. disenrollment of enrollees as described in Section 2-22 and 4; or
4. limitation of the CONTRACTOR's Service Area as described in Section 2-22 and 4.

6-8.2 Liquidated Damages

6-8.2.1 Reports and Deliverables

For each day that a report or deliverable is late, incorrect, or deficient, the CONTRACTOR shall be liable to TENNCARE for liquidated damages in the amount of \$100 per work day per report or deliverable. Liquidated damages for late reports shall begin on the first day the report is late. Liquidated damages for incorrect reports (except ad hoc or on-request reports involving provider network information), or deficient deliverables shall begin on the sixteenth day after notice is provided from TENNCARE to the CONTRACTOR that the report remains incorrect or the deliverables remain deficient; provided, however, that it is reasonable to correct the report or deliverable within fifteen (15) calendar days. For the purposes of ad hoc or on-request reports involving provider network information, liquidated damages for incorrect reports shall begin on the first day the report is determined by TENNCARE to be incorrect. For the purposes of determining liquidated damages in accordance with this Section, reports or deliverables are due in accordance with the following schedule, unless otherwise specified elsewhere in this Agreement:

DELIVERABLES	DATE AGREED UPON BY THE PARTIES
Daily Reports	Within two (2) working days.

Weekly Reports	Wednesday of the following week.
Monthly Reports	20th of the following month.
Quarterly Reports, excluding SURS	30th of the following month.
Annual Reports	Ninety (90) calendar days after the end of the year.
On Request Reports	Within three (3) working days from the date of request when reasonable unless otherwise specified by TENNCARE.
Ad Hoc Reports	Within ten (10) working days from the date of the request when reasonable unless otherwise specified by TENNCARE.

6-8.2.2 Program Issues

Liquidated damages for failure to perform specific responsibilities as described in this Agreement are shown below. Damages are grouped into three categories: **Class A** violations, **Class B** violations, and **Class C** violations.

Class A violations are those which pose a significant threat to patient care or to the continued viability of the TENNCARE program.

Class B violations are those with pose threats to the integrity of the TENNCARE program, but which do not necessarily imperil patient care.

Class C violations are those which represent threats to the smooth and efficient operation of the TENNCARE program but which do not imperil patient care or the integrity of the TENNCARE program.

CLASS	PROGRAM ISSUES	DAMAGE
A.1	Failure to comply with claims processing as described in Section 2-9.7 of this Agreement	\$10,000 per month, for each month that TENNCARE determines that the CONTRACTOR is not in compliance with the requirements of Section 2-9.7 of this Agreement.
A.2	Failure to respond to a request by DCS or TENNCARE to provide service(s) to a child in DCS custody or at risk of entering DCS custody as described in Section 3 of this Agreement	\$1000 per occurrence
A.3	Failure to comply with obligations and timeframes in the delivery of EPSDT screens and related services	\$1000 per occurrence
A.4	Denial of a request for services to a child in DCS custody or at risk of entering	\$1000 per occurrence

	DCS custody when the services have been reviewed and authorized by the TENNCARE Chief Medical Officer	
A.5	Failure to provide a service or make payments for a service within five (5) calendar days of a reasonable and appropriate directive from TENNCARE to do so or within a longer period of time which has been approved by TENNCARE upon a plan's demonstration of good cause.	\$500 per day beginning on the next calendar day after default by the plan.
A.6	Failure to comply with this Agreement and federal rules/law regarding Sterilizations/Abortions/ Hysterectomies as outlined in Section 2-3.11 of this Agreement	\$500 per violation or the actual amount of the federal penalty created by this violation, whichever is greater.
A.7	Failure to provide a two (2) week supply of prescribed medication in accordance with Section 2-3.13 of this Agreement and the TennCare Rules and Regulations	\$100 per occurrence, and due immediately, upon notification by TENNCARE for each occurrence that TENNCARE determines that the requirements in this provision have not been met.
A.8	Failure to provide coverage for prenatal care without a delay in care and in accordance with the terms of this Agreement	\$500 per day, per occurrence, for each day that care is not provided in accordance with the terms of this Agreement.
A.9	Services wrongfully withheld where enrollee was not receiving the service and the enrollee went without coverage of the disputed service while an appeal on the service was pending.	\$1,000 per occurrence
A.10	Failure to comply with the notice requirements of the TENNCARE rules and regulations or any subsequent amendments thereto, and all court orders governing appeal procedures, as they become effective.	\$500 per calendar day for each day beyond the required time frame that the appeal is unanswered in each and every aspect and/or each day the appeal is not handled according to the provisions set forth by this Agreement or required by TENNCARE
A.11	Failure to provide continuation or restoration of services where enrollee was receiving the service as required by the TENNCARE rules or any subsequent amendments thereto, all applicable state or federal law, and all court orders governing appeal procedures as they become effective.	\$500 per occurrence.
A.12	Failure to forward an expedited appeal to TENNCARE in twenty-four (24) hours or a standard appeal in five (5) days.	\$500 per calendar day.

B.1	Failure to report Specialty listings to PCP providers as required by this Agreement	\$500 per calendar day.
B.2	Failure to complete or comply with corrective action plans as required by TENNCARE	\$500 per calendar day for each day the corrective action is not completed or complied with as required.
C.1	Employment of licensed personnel	\$250 per calendar day for each day that personnel are not licensed as required by applicable state law and/or regulations.
C.2	Failure to comply in any way with staffing requirements as described in Section 2-9 of this Agreement	\$250 per calendar day for each day that staffing requirements as described in Section 2-9 of this Agreement are not met.
C.3	Failure to report provider notice of termination of participation in the CONTRACTOR's plan	\$200 per day.

6-8.2.3 *Payment of Liquidated Damages*

It is further agreed by TENNCARE and the CONTRACTOR that any liquidated damages assessed by TENNCARE shall be due and payable to TENNCARE within thirty (30) calendar days after CONTRACTOR receipt of the notice of damages and if payment is not made by the due date, said liquidated damages may be withheld from future administrative payments by TENNCARE without further notice. It is agreed by TENNCARE and the CONTRACTOR that the collection of liquidated damages by TENNCARE shall be made without regard to any appeal rights the CONTRACTOR may have pursuant to this Agreement; however, in the event an appeal by the CONTRACTOR results in a decision in favor of the CONTRACTOR, any such funds withheld by TENNCARE will be immediately returned to the CONTRACTOR. Any cure periods referenced in this Agreement shall not apply to the liquidated damages described in this Section. With respect to Class B and Class C violations, the due dates mentioned above may be delayed if the CONTRACTOR can show good cause as to why a delay should be granted. TENNCARE has sole discretion in determining whether good cause exists for delaying the due dates.

Liquidated damages as described in Section 6.7.2 shall not be passed to a provider and/or subcontractor unless the damage was caused due to an action or inaction of the provider and/or subcontractor. Nothing described herein shall prohibit a provider and/or a subcontractor from seeking judgement before an appropriate court in situations where it is unclear that the provider and/or the subcontractor caused the damage by an action or inaction.

All liquidated damages imposed pursuant to this Agreement, whether paid or due, shall be paid by the CONTRACTOR out of administrative and management costs and profits.

6-9 **Amendments**

This Agreement may be amended at anytime as provided in this paragraph. This Agreement shall be amended automatically without action by the parties whenever required by changes in state and federal law or regulations. In the event of a Partial Default, the Agreement shall be amended automatically to conform with written notices from TENNCARE of the CONTRACTOR regarding the effect of the Partial Default upon this Agreement. No other modification or change of any provision of the Agreement shall be made or

construed to have been made unless such modification is mutually agreed to in writing by the CONTRACTOR and TENNCARE and incorporated as a written amendment to this Agreement prior to the effective date of such modification or change.

6-10 Titles

Titles of paragraphs used herein are for the purpose of facilitating use or reference only and shall not be construed to infer a contractual construction of language.

6-11 Offer of Gratuities

By signing this Agreement, the CONTRACTOR signifies that no member of or a delegate of Congress, nor any elected or appointed official or employee of the State of Tennessee, the General Accounting Office, Department of Health and Human Services, HCFA, or any other federal agency has or will benefit financially or materially from this procurement. This Agreement may be terminated by TENNCARE if it is determined that gratuities of any kind were offered to or received by any of the aforementioned officials or employees from the CONTRACTOR, his agent, or employees.

6-12 Inspection of Work Performed

TENNCARE or its authorized representative shall, at all reasonable times, have the right to enter into the CONTRACTOR's premises, or such other places where duties of this Agreement are being performed, to inspect, monitor, or otherwise evaluate including periodic audits of the work being performed. The CONTRACTOR and all other subcontractors or providers must supply reasonable access to all facilities and assistance for TENNCARE's representatives. All inspections and evaluations shall be performed in such a manner as to minimize disruption of normal business.

6-13 Attorney's Fees

In the event that either party deems it necessary to take legal action to enforce any provision of this Agreement, and TENNCARE prevails, the CONTRACTOR agrees to pay all expenses of such action, including attorney's fees and cost of all state litigation as may be set by the court or hearing officer. Legal actions are defined to include administrative proceedings.

6-14 Court of Jurisdiction or Venue

For purposes of any legal action occurring as a result of or under this Agreement between the CONTRACTOR and TENNCARE, the place of proper venue shall be Davidson County, Tennessee.

6-15 Assignment

This Agreement and the monies that may become due hereunder are not assignable by the CONTRACTOR except with the prior written approval of TENNCARE.

6-16 Independent Contractor

It is expressly agreed that the CONTRACTOR and any subcontractors or providers, and agents, officers, and employees of the CONTRACTOR or any subcontractors or providers, in the performance of this Agreement shall act in an independent capacity and not as agents, officers and employees of TENNCARE or the State of Tennessee. It is further expressly agreed that this Agreement shall not be construed as a partnership or joint venture between the CONTRACTOR or any subcontractor or provider and TENNCARE and the State of Tennessee.

6-17 Force Majeure

TENNCARE shall not be liable for any excess administrative cost to the CONTRACTOR for TENNCARE's failure to perform the duties required by this Agreement if such failure arises out of causes beyond the control and without the result of fault or negligence on the part of TENNCARE. In all cases, the failure to perform must be beyond the control without the fault or negligence of TENNCARE. The CONTRACTOR shall not be liable for performance of the duties and responsibilities of this Agreement when its ability to perform is prevented by causes beyond its control. These acts must occur without the fault or negligence of the CONTRACTOR. Such acts include destruction of the facilities due to hurricanes, fires, war, riots, and other similar acts. However, in the event of damage to its facilities, the CONTRACTOR will be responsible for insuring swift correction of the problem so as to enable it to continue its responsibility for the delivery of health care. The failure of the CONTRACTOR's fiscal intermediary to perform any requirements of this Agreement shall not be considered a 'force majeure'.

6-18 Disputes

Any claim by the CONTRACTOR against TENNCARE arising out of the breach of this Agreement shall be handled in accordance with the provision of T.C.A. Section 9-8-301, et. seq. Provided, however, the CONTRACTOR agrees that the CONTRACTOR shall give notice to TENNCARE of its claim thirty (30) calendar days prior to filing the claim in accordance with T.C.A. Section 9-8-301, et. seq.

6-19 Indemnification

The CONTRACTOR shall indemnify and hold harmless the State as well as its officers, agents, and employees (hereinafter the "Indemnified Parties") from all claims, losses or suits incurred by or brought against the Indemnified Parties as a result of the failure of the CONTRACTOR to comply with the terms of this Agreement. The State shall give the CONTRACTOR written notice of each such claim or suit and full right and opportunity to conduct CONTRACTOR's own defense thereof, together with full information and all reasonable cooperation; but the State does not hereby accord to the CONTRACTOR, through its attorneys, any right(s) to represent the State of Tennessee in any legal matter, such right being governed by T.C.A. Section 8-6-106.

The CONTRACTOR shall indemnify and hold harmless the Indemnified Parties as well as their officers, agents, and employees from all claims or suits which may be brought against the Indemnified Parties for infringement of any laws regarding patents or copy rights which may arise from the CONTRACTOR's or Indemnified Parties performance under this Agreement. In any such action, brought against the Indemnified Parties, the CONTRACTOR shall satisfy and indemnify the Indemnified Parties for the amount of any final judgment for infringement. The State shall give the CONTRACTOR written notice of each such claim or suit and full right and opportunity to conduct the CONTRACTOR's own defense thereof, together with full information and all reasonable cooperation; but the State does not hereby accord to the CONTRACTOR, through its attorneys, any right(s) to represent the State of Tennessee in any legal matter, such right being governed by T.C.A. Section 8-6-106.

While the State will not provide a contractual indemnification to the CONTRACTOR, such shall not act as a waiver or limitation of any liability for which the State may otherwise be legally responsible to the CONTRACTOR. The CONTRACTOR retains all of its rights to seek legal remedies against the State for losses the CONTRACTOR may incur in connection with the furnishing of services under this Agreement or the failure of the State to meet its obligations under the Agreement.

6-20 Non-Discrimination

No person on the grounds of handicap, and/or disability, age, race, color, religion, sex, or national origin, shall be excluded from participation in, except as specified in Section 2 of this Agreement, or be denied benefits of, or be otherwise subjected to discrimination in the performance of this Agreement or in the employment practices of the CONTRACTOR. The CONTRACTOR shall upon request show proof of such non-discrimination, and shall post in conspicuous places, available to all employees and applicants, notices of non-discrimination.

6-21 Confidentiality of Information

The CONTRACTOR shall assure that all material and information, in particular information relating to enrollees or potential enrollees, which is provided to or obtained by or through the CONTRACTOR's performance under this Agreement, whether verbal, written, tape, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under state and federal laws. The CONTRACTOR shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under this Agreement.

All information as to personal facts and circumstances concerning enrollees or potential enrollees obtained by the CONTRACTOR shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of TENNCARE or the enrollee/potential enrollee, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning enrollees/potential enrollees shall be limited to purposes directly connected with the administration of this Agreement.

6-22 Actions Taken by the Tennessee Department of Commerce and Insurance

The parties acknowledge that the CONTRACTOR is licensed to operate as a health maintenance organization in the State of Tennessee, and is subject to regulation and supervision by the Tennessee Department of Commerce and Insurance. The parties acknowledge that no action by the Department of Commerce and Insurance to regulate the activities of the CONTRACTOR as a health maintenance organization, including, but not limited to, examination, entry of a remedial order pursuant to T.C.A. Section 56-9-101, *et seq.*, and regulations promulgated thereunder, supervision, or institution of delinquency proceedings under state law, shall constitute a breach of this Agreement by TENNCARE.

6-23 Effect of the Federal Waiver on this Agreement

The provisions of this Agreement are subject to the receipt of and continuation of a federal waiver granted to the State of Tennessee by the Health Care Financing Administration, U.S. Department of Health and Human Services. Should the waiver cease to be effective, the State shall have the right to immediately terminate this Agreement. Said termination shall not be a breach of this Agreement by TENNCARE and

TENNCARE shall not be responsible to the CONTRACTOR or any other party for any costs, expenses, or damages occasioned by said termination.

6-24 TENNCARE Financial Responsibility

Notwithstanding any provision which may be contained herein to the contrary, TENNCARE shall be responsible solely to the CONTRACTOR for the amount described herein and in no event shall TENNCARE be responsible, either directly or indirectly, to any subcontractor or any other party who may provide the services described herein.

6-25 Records

The CONTRACTOR shall maintain documentation for all charges against the State under this Contract. The books records, and documents of the CONTRACTOR, insofar as they relate to work performed or money received under this contract, shall be maintained for a period of three (3) full years from the date of the final payment and shall be subject to audit at any reasonable time and upon reasonable notice by the state. Financial statements shall be prepared in accordance with Generally Accepted Accounting Practices.

6-26 Contract Term of The Agreement

This Agreement and its incorporated attachments, if any, as well as all Amendments to this Agreement, contain all of the terms and conditions agreed upon by the parties, and when executed by all parties, supersedes any prior agreements. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall be in effect from July 1, 2001, subject to approval by the U.S. Department of Health and Human Services, Health Care Financing Administration. The term of this Agreement shall expire on December 31, 2002.

Notwithstanding any provision herein to the contrary, the State may terminate this Agreement if the waiver governing TennCare is terminated. The documents referenced in the Agreement are on file with the CONTRACTOR and with TENNCARE and the CONTRACTOR is aware of their content. No other agreement, oral or otherwise regarding the subject matter of this Agreement, shall be deemed to exist or to bind any of the parties hereto.

6-27 Performance Guarantees

The CONTRACTOR agrees TennCare may assess the penalties specified below upon a finding that the CONTRACTOR is out of compliance with the performance guarantees identified below for the duration of this Agreement.

Claims Payment Accuracy

Guarantee	Average monthly payment accuracy will be 97% or higher on initial processing.
Definition	Number of claims paid accurately upon initial submission divided by the total number of claims.
Penalty	\$5,000 for each full percentage point accuracy is below 97% for each quarter.
Monitoring Tool	Internal audit conducted on statistically valid random sample on a quarterly basis.

Telephone Response Time

Guarantee	Calls not answered shall be less than 5% of total calls.
Definition	Percent of calls not answered; callers hang up while in queue.
Penalty	\$25,000 for each full percentage point over the Guarantee on a quarterly basis, except when substantial changes in call volume tied to mass mailings sent from TennCare.
Monitoring Tool	Weekly Activity Report

Identification Card Distribution

Guarantee	Member ID cards distributed to 100% of enrollees within 30 days of receipt of notice of enrollment.
Definition	Post mark date plus 5 days.
Penalty	\$25,000 per open enrollment period in which the standard is not meet.
Monitoring Tool	Measured, reported and reconciled annually

Focused Studies

Guarantee	Timely completion of all required focused studies as specified in Attachment II.
Definition	As defined in Attachment II.
Penalty	\$25,000 for failure to complete or untimely completion of focused studies.
Monitoring Tool	EQRO annual report

EPSDT

Guarantee	10 percentage point improvement over average MCO fiscal year 2000 APSP screening rate for SSI children; and 10 percentage point improvement over average fiscal year 2000 APSP EPSDT screening rate for all other children (not applicable to Revised Remedial Plan population).
Definition	The percentage of eligible children who receive complete EPSDT screens in a year. This percentage is calculated by multiplying (1) the annual percentage of children who receive a screening by (2) the percentage of the required seven components that are contained in a statistically valid sample of EPSDT screens.
Penalty	\$10,000 for each full percentage point below the required increase.
Monitoring Tool	Screening rate measured and reported annually. Results of independent medical chart review conducted by an entity designated by the state applied to calculate APSP.

TPL Recoveries

Guarantee	The CONTRACTOR shall make all reasonable efforts to produce third party liability recoveries of at least three percent (3%) of paid claims per fiscal year for Medicaid eligibles and at least four percent of claims paid (4%) per fiscal year for Disabled eligibles.
Definition	Any amount due for all or part of the cost of medical care from a third party (excluding enrollee cost-sharing).
Penalty	Not applicable.
Monitoring Tool	Measured, reported and reconciled as of June 30, 2002 and as of December 31, 2002.

7 STATE RESPONSIBILITIES

7-1 General Responsibilities

TENNCARE shall be responsible for management of this Agreement. Management shall be conducted in good faith with the best interest of the State and the citizens it serves being the prime consideration. Management of TennCare shall be conducted in a manner consistent with simplicity of administration and the best interests of enrollees, as required by 42 U.S.C. Section 1396a(a)(19).

The State shall review and may require modifications to all policies related to the implementation of this Agreement. Should the CONTRACTOR have a question on policy determinations, benefits, or operating guidelines required for proper performance of the Contractor's responsibilities, the CONTRACTOR shall request a determination in writing. The State will then respond in writing making a determination within thirty (30) days. The CONTRACTOR shall then act in accordance with such policy determinations and/or operating guidelines.

7-2 Eligibility Determination

The State shall have sole responsibility for determining the eligibility of an individual for TennCare funded services. Nonetheless the CONTRACTOR shall not cause to be submitted to TENNCARE applications for enrollment for persons that the CONTRACTOR knew or reasonably should have known were ineligible pursuant to Section 4 of this Agreement.

The State shall provide eligibility records. These records shall include changes in enrollee's status. The CONTRACTOR's computer system shall be compatible or have the capability to utilize the eligibility information provided by the State.

7-3 Approval Process

At any time that approval of TENNCARE is required in this Agreement, such approval shall not be considered granted unless TENNCARE issues its approval in writing. Should TENNCARE not respond in the required amount of time, as set forth in Attachment I, the CONTRACTOR shall not be penalized as a result of implementing the item awaiting approval. However, failure by TENNCARE to assess liquidated damages or penalties shall not preclude TENNCARE from requiring the CONTRACTOR to rescind or modify the "item" if it is determined by TENNCARE to be in the best interest of the TennCare program. Material requiring TENNCARE approval includes, at a minimum, the following:

- a. Fraud and Abuse Compliance Plan;
- b. Provider network;
- c. Marketing and/or enrollee plans, materials and all related materials to be used in soliciting enrollment, educating or communicating with existing enrollees;
- d. Drug formulary and all subsequent changes (applicable only if a closed formulary);
- e. Subcontracts;
- f. Indemnity language in provider agreements if different than standard indemnity language found in Section 6-18 of this Agreement;

- g. Quality Monitoring/Quality Improvement procedures;
- h. Insurance and bonding plans;
- i. Alternative method of pharmacy restriction procedures for pharmacy abusers;
- j. MCO/BHO Coordination Agreement;
- k. Medical management policies and procedures, as requested; and
- l. Termination Plan.

7-4 Interpretations

Any dispute between the CONTRACTOR and TENNCARE concerning the clarification, interpretation and application of all federal and state laws and regulations governing or in any way affecting this Agreement shall be determined by TENNCARE. When a clarification, interpretation and application is required, the CONTRACTOR will submit written requests to TENNCARE. TENNCARE will contact the appropriate agencies in responding to the request by submitting the written request to the agency within thirty (30) days after receiving that request from the CONTRACTOR. Any clarifications received pursuant to requests for clarification or interpretation shall be forwarded upon receipt to the CONTRACTOR. Nothing in this Section shall be construed as a waiver by the CONTRACTOR of any legal right it may have to contest the findings of either the state or federal governments or both as they relate to the clarification, interpretation and application of statute, regulation, and/or policy.

7-5 Facility Inspection

TENNCARE, the Health Care Financing Administration, or their agents may conduct on-site inspections of all health facilities and service delivery sites to be utilized by the CONTRACTOR in fulfilling the obligations under this Agreement. Inspections may be made at anytime during the Agreement period and without prior notice.

7-6 Monitoring

TENNCARE, in its daily activities, shall monitor various aspects of the CONTRACTOR's health plan for compliance with the provisions of this Agreement. Further, TENNCARE, the Health Care Financing Administration, or their agents shall at least annually monitor the operation of the CONTRACTOR for compliance with the provisions of this Agreement and applicable federal and state laws and regulations. Such monitoring activities shall include, but are not limited to, inspection of CONTRACTOR's facilities, auditing and/or review of all records developed under this Agreement including periodic medical audits, appeals, enrollments, disenrollments, termination, utilization and financial records, reviewing management systems and procedures developed under this Agreement and review of any other areas or materials relevant to or pertaining to this Agreement. Because of the importance of having accurate service utilization data for program management, utilization review and evaluation purposes, emphasis will be placed on case record validation during periodic monitoring visits to project sites. TENNCARE shall prepare a report of its findings and recommendations and require the CONTRACTOR to develop corrective action plans as appropriate.

7-7 Enrollment, Disenrollment and Eligibility Verification

TENNCARE shall be responsible for the receipt of applications for TennCare eligibility, verification of the data contained on the application, determination of the applicability of cost sharing amounts and collection of applicable premiums. TENNCARE shall also be responsible for enrollment of eligible persons in the CONTRACTOR'S plan and for disenrollment of ineligible persons from the CONTRACTOR'S plan. TENNCARE will arrange for the CONTRACTOR to have updated eligibility information in the form of on-line computer access and will notify the CONTRACTOR when TENNCARE determines that an enrollee has moved. TENNCARE may provide the CONTRACTOR with a report containing enrollees for whom TENNCARE has been unable to locate or verify various types of pertinent information. Upon receipt of this report, the CONTRACTOR shall provide TENNCARE with any information that is known by the CONTRACTOR that may affect an enrollee's TennCare eligibility and/or cost sharing responsibilities including changes in income, family size, access to health insurance, proof of uninsurability, including limited coverage and exclusionary riders to policies, change of residence or residence outside the State of Tennessee.

TENNCARE shall not enroll applicants as the result of enrollment applications submitted by a CONTRACTOR or anyone acting on its behalf.

In accordance with Section 2-22 of this Agreement, TENNCARE has authorized the CONTRACTOR to serve one or more community service areas within a Grand Region. TENNCARE shall maintain the flexibility to freeze enrollment, or begin disenrollment in one or more area(s) of the CONTRACTOR's plan if TENNCARE determines it to be in the best interest of enrollees, the CONTRACTOR's plan and/or the TennCare program. However, during such periods that TENNCARE has suspended enrollment in an area(s), TENNCARE shall maintain the flexibility to allow enrollees to continue to be enrolled in such areas when; 1) the enrollee is a member of the same household that is currently in the CONTRACTOR's plan, 2) it is determined necessary by TENNCARE due to an emergent or hardship case, or 3) the enrollee had requested enrollment in the CONTRACTOR's plan prior to closure of additional enrollment.

7-8 Appeal

Enrollees may request state level review of adverse cost-sharing enrollment and financial obligation related decisions to TENNCARE. The state level review will be conducted in accordance with the TENNCARE rules and regulations. The CONTRACTOR is bound by the state level decision.

7-9 Technical Assistance

Technical assistance shall be provided to the CONTRACTOR when deemed appropriate by TENNCARE. Technical assistance shall be provided to the CONTRACTOR when deemed appropriate by TENNCARE. Refer to Section 2-9 Part a Subpart 10 regarding TAGS.

7-10 Payments to the CONTRACTOR

The State shall pay the CONTRACTOR as specified in Section 6 of this Agreement.

7-10.1 Effect of Disenrollment on Administrative Fee Payments

Payment of the administrative fee shall cease effective the date of disenrollment and the CONTRACTOR shall have no further responsibility for the care of the enrollee. Except for situations involving enrollment obtained by fraudulent applications or death, disenrollment from TennCare shall not be made retroactively.

The CONTRACTOR shall not be required to refund any administrative fee amounts legitimately paid pursuant to this Agreement. In the case of fraudulent, misrepresented or deceptive applications submitted by the enrollee, the CONTRACTOR, at its discretion, may refund to TENNCARE all administrative fee payments made on behalf of persons who obtained enrollment in TennCare through such means and the CONTRACTOR may pursue full restitution for all payments made for medical care while the person was inappropriately enrolled in the CONTRACTOR's plan. In the event of enrollment obtained by fraud, misrepresentation or deception of individuals by the CONTRACTOR's staff, officers, employees, providers, volunteers, subcontractors, or anyone acting for or on behalf of the CONTRACTOR, TENNCARE may retroactively recover administrative fee payments, medical services payments plus interest as allowed by TCA 47-14-103, and HMO payments and any other monies paid to any CONTRACTOR for the enrollment of that individual. The refund of administrative fee and medical services payments plus interest and HMO payments will not preclude the State from exercising its right to criminal prosecution, civil penalties, trebled *damages and/or other remedial measures*.

7-11 Services Provided by TennCare

TennCare shall be responsible for the payment of the following services:

- a. For qualified individuals in accordance with TennCare policies and/or TennCare rules and regulations, costs of long term care institutional services in a nursing home, or an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or waiver-covered services provided through the Home and Community Based Services (HCBS) waivers, with the exception of the first one hundred (100) days of convalescent care, as described in Section 2-3.1 and 2-3.7 of this Agreement;
- b. Medicare buy-in premiums, Medicare deductibles and Medicare coinsurance amounts for enrollees who are dually eligible for Medicare and Medicaid; and
- c. Pharmacy Benefits for Medicare and TennCare dual eligibles after TENNCARE has notified the CONTRACTOR through the regular electronic eligibility update that these individuals are eligible in the TennCare/Medicare dual eligible category.

7-12 Program Information

Upon request, TENNCARE shall provide the CONTRACTOR complete and current information with respect to pertinent statutes, regulations, rules, policies, procedures, and guidelines affecting the CONTRACTOR's operation pursuant to this Agreement.

7-13 Pharmacy Encounter Data

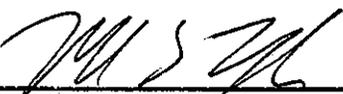
The TENNCARE Bureau will provide to each MCO, monthly pharmacy encounter data for all the MCO's enrollees whose claims are the financial responsibility of TENNCARE, including TennCare/Medicare enrollees assigned to the MCO to the extent allowed by state and federal law. This data exchange will allow the MCO's to integrate this information into their case management and medical management systems to improve the quality of care for TennCare enrollees.

7-14 Exigency Extension

In the event of delay in the procurement for an Administrator to assume the responsibilities specified in this Agreement as of January 1, 2003, the CONTRACTOR agrees to continue services for TennCare for three months. Subsequently, if the issue resulting in a delay has not been resolved or in the event of a procurement failure, the CONTRACTOR agrees to continue services for an additional nine months. Thirty (30) days notice shall be given by the Department before either option is exercised. During any period of exigency, the penalties specified at Sections 3-1.9 and 6-27 shall not be applied. TennCare shall reimburse the CONTRACTOR during exigency period at the established administrative fee in effect during the last six (6) months of this Agreement plus an inflation factor consistent with previous increases.

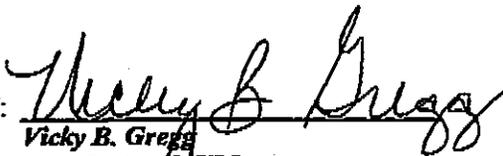
IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: 
Mark E. Reynolds
Deputy Commissioner

DATE: June 28, 2001

VOLUNTEER STATE HEALTH PLAN, INC.

BY: 
Vicky B. Gregg
President and CEO

DATE: June 28, 2001

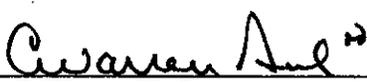
STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: 
C. Warren Neel
Commissioner

DATE: 6/29/01

APPROVED BY:

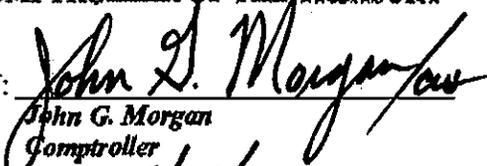
STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: 
C. Warren Neel
Commissioner

DATE: 6-29-01

APPROVED BY:

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

BY: 
John G. Morgan
Comptroller

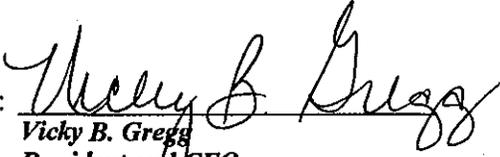
DATE: 7/5/01

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

VOLUNTEER STATE HEALTH PLAN, INC.

BY: _____
Mark E. Reynolds
Deputy Commissioner

BY: 
Vicky B. Gregg
President and CEO

DATE: _____

DATE: June 28, 2001

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

BY: _____
C. Warren Neel
Commissioner

DATE: _____

APPROVED BY:

APPROVED BY:

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

**STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY**

BY: _____
C. Warren Neel
Commissioner

BY: _____
John G. Morgan
Comptroller

DATE: _____

DATE: _____

ATTACHMENTS

ATTACHMENT I - DELIVERABLE REQUIREMENTS

ATTACHMENT I

Deliverable Requirements

The CONTRACTOR and TENNCARE are responsible for complying with all the deliverable requirements established by the parties. Both parties are responsible for assuring the accuracy and completeness of all deliverables as well as the timely submission of each deliverable. Both parties will agree to the appropriate deliverable instructions, submission timetables, and technical assistance as required.

I. Items requiring prior approval by TENNCARE

- | | | |
|----|---|--|
| A. | Fraud and Abuse Compliance Plan | TENNCARE has thirty (30) calendar days to respond |
| B. | Provider Network | TENNCARE has thirty (30) calendar days to respond |
| C. | Marketing/Enrollee Materials and/or Plans | TENNCARE has fifteen (15) calendar days to respond |
| D. | Drug Formulary (if closed) | TENNCARE has thirty (30) calendar days to respond |
| E. | Subcontracts | TENNCARE has thirty (30) calendar days to respond |
| F. | Indemnity language in provider agreements if different than standard indemnity language | TENNCARE has fifteen (15) calendar days to respond |
| G. | Quality Monitoring/Quality Improvement Process | TENNCARE has thirty (30) calendar days to respond |
| H. | Insurance and Bonding Plans | TENNCARE has fifteen (15) calendar days to respond |
| I. | Alternative method of pharmacy restriction procedures for Pharmacy Abusers | TENNCARE has fifteen (15) calendar days to respond |
| J. | MCO/BHO Coordination Agreement | TENNCARE has thirty (30) calendar days to respond |
| K. | Medical Management Policies and Procedures | TENNCARE has thirty (30) calendar days to respond |
| L. | Termination Plan | TENNCARE has thirty (30) calendar days to respond |

II. Deliverables which are the responsibility of the CONTRACTOR

- | | | |
|----|--|---|
| A. | Listing of referral providers in accordance with Section 2-4.4 | Due to providers within thirty (30) calendar days following the execution of this Agreement and quarterly thereafter on a calendar year schedule. Proof of compliance shall be sent to the Office of Contract Development and Compliance by the 30 th of the month following each quarter. |
|----|--|---|

- | | | |
|----|---|--|
| B. | FQHC Reporting in accordance with 2-4.9.1 and 2-10.12 | Due January 1 of each year to Office of Contract Development and Compliance |
| C. | Complete Drug Formulary; if CONTRACTOR utilizes a closed drug formulary, and a complete description of prior authorization criteria for each drug requiring prior authorization via electronic file in accordance with Section 3-13 | Due January 1 of each year to TENNCARE Pharmacy Director |
| D. | Quarterly Newsletter in accordance with Section 2-6.2 | Due quarterly, within one hundred twenty (120) calendar days of the prior quarters' newsletter to enrollees and to the Office of Contract Development and Compliance (10 copies) |
| E. | Reports of appeal and resolution in accordance with Section 2-8 and 2-10.13 | Quarterly, by the 30 th of the following month to the TennCare Solutions Unit Director |
| F. | Identify key staff contacts in accordance with Section 2-10.10.2 and 2-9.2 | Due within thirty (30) calendar days of Agreement execution and within ten (10) business days of any changes to the Office of Contract Development and Compliance |
| G. | Performance Indicator Reporting in accordance with Section 2-9.6.2 and 2-10.14.4 | Annually, within ninety (90) calendar days of the end of the calendar year to the Office of the TennCare Medical Director |
| H. | Weekly Claims Activity Reporting in accordance with Section 2-10.6 | Weekly, by Wednesday of the following week to the Department of Commerce and Insurance, TennCare Division |
| I. | Enrollee Information as described in Section 2-10.2.1 | Weekly, by Wednesday of the following week to TENNCARE, Information Systems Section |
| J. | Eligibility and Administrative Fee Payment reconciliation as described in Section 2-10.2.3 | Quarterly, by the 30 th of the following month to the TENNCARE Information Systems Section |
| K. | Enrollee Cost-Sharing in accordance with Section 2-10.2.4 | Quarterly, by the 30 th of the following month to TennCare Information Systems Section |
| L. | Provider Enrollment listing in accordance with Section 2-10.3.1 | Monthly, within five (5) working days following the end of the month, to the TennCare Information Systems Section |
| M. | Unduplicated listing of all providers and their unique identifying provider numbers cross-referenced to the Medicaid servicing provider number in accordance with Section 2-10.3.1 | Within ten (10) working days of a request by TENNCARE to the TennCare Information Systems Section |
| N. | Listing of Essential Hospital Providers in the MCO's provider network in accordance with Section 2-10.3.2 | Within sixty (60) calendar days of Agreement execution, thereafter by September 1 of each year |

O.	Listing of Specialty Physician Arrangements in accordance with Section 2-10.3.2	Within sixty (60) calendar days of Agreement execution, thereafter by September 1 of each year
P.	Reporting Other Insurance in accordance with Section 2-10.4	To be Determined
R.	Individual Encounter Reporting in accordance with 2-10.5	Monthly, by the 15 th of the following month, to TENNCARE, Information Systems Section
S.	Weekly Activity Reporting in accordance with Section 2-10.7	Weekly, by Wednesday of the following week to Office of Contract Development and Compliance
T.	Network Clearing House Reporting in accordance with Section 2-10.8	At TENNCARE's request
U.	Annual Report - Submitted on a form prescribed by the National Association of Insurance Commissioners in accordance with Section 2-10.9	Due on or before March 1 of each calendar year to The Department of Commerce and Insurance, TennCare Division
V.	Quarterly Financial Report - Submitted on a form prescribed by the National Association of Insurance Commissioners in accordance with Section 2-10.9	Due on or before June 1, September 1, and December 1 in accordance with Section 2-10.9 of this Agreement to be submitted to The Department of Commerce and Insurance, TennCare Division
W.	Audit of Business Transactions/ Audited Financial Statements in accordance with Section 2-10.9	Due on or before May 1 of each calendar year to The Department of Commerce and Insurance, TennCare Division
X.	Board of Directors in accordance with Section 2-10.10.3	At the beginning of the Agreement period and within ten (10) business days of a change to Office of Contract Development and Compliance
Y.	Cost and Utilization Summaries in accordance with 2-10.11	As specified at 2-10.11
Z.	QM Reports – Continuous Focused Studies in accordance with 2-10.14.1. and Attachment II	Within ninety (90) calendar days of the end of the calendar year to the Office of the TENNCARE Medical Director
AA.	QM Reports – Quarterly Focused Studies in accordance with 2-10.14.2 and Attachment II	Within thirty (30) calendar days of the end of the quarter to the Office of the TENNCARE Medical Director
BB.	QM Reports – Continuity of Care Reporting in accordance with 2-10.14.3 and Attachment II	Within thirty (30) calendar days of the end of the quarter to the Office of the TENNCARE Medical Director
CC.	All required QM/QI reports in accordance with 2-10 and Attachment II	As specified, to the office of the TENNCARE Medical Director
DD.	Written plan of changes resulting from monitoring and audit in accordance with Section 2-16	Within fifteen (15) working days after receipt of notice of deficiencies to the Office of Contract Development and Compliance

EE.	Ownership and Financial Disclosure in accordance with Section 2-21	With Agreement, and annually thereafter by March 1 of every year to the Office of Contract Development and Compliance
FF.	Significant business transaction in accordance with Section 2-21	Upon Occurrence to the Department of Commerce and Insurance, TennCare Division
GG.	Annual submission of personnel/ operational policies that emphasize non-discrimination in hiring, promotional and contracting processes as described in Section 2-24	Annually, within ninety (90) calendar days after the end of the year to the Title VI compliance officer
HH.	Quarterly listing of complaints/ appeals filed alleging discrimination as described in Section 2-24	Quarterly, by the 30 th of the following month to the Title VI compliance officer
II.	Quarterly listing of supervisory personnel as described in Section 2-24	Quarterly, by the 30 th of the following month to the Title VI compliance officer
JJ.	Annual listing by CSA of non-institutional providers as described in Section 2-24	Annually, within ninety (90) calendar days after the end of the year to the Title VI compliance officer
KK.	Annual copy of CONTRACTOR's policy regarding non-discrimination of services to persons with Limited English Proficiency as described in Section 2-24	Annually, within ninety (90) calendar days after the end of the year to the Title VI compliance officer
LL.	On a Quarterly basis, a listing of all request of translation or interpreter services as described in Section 2-24.g.1.	Quarterly, by the 30 th of the following month to the compliance officer
MM.	Annual Compliance Plan as described in Section 2-24	On an annual basis to the Title VI compliance officer

III. Deliverables which are the responsibility of TENNCARE

- A. Reports concluding findings, recommendations and requirements resulting from monitoring procedures by TENNCARE and/or HCFA.
- B. Updated eligibility information in the form of electronic submissions.
- C. Medicare/TennCare dual eligible pharmacy information monthly.
- D. Notice of any consent decree entered into by the State within 72 hours of the decree being entered with court and notice of other court orders affecting MCO participation in the TennCare Program within seventy-two (72) hours of receipt in the Attorney General's Office.
- E. Notice of any enrollees who have exceeded the out-of-pocket maximum for whom the MCO must coordinate reimbursement, on a schedule to be specified by TENNCARE.

ATTACHMENT II - QUALITY OF CARE MONITORS

**ATTACHMENT II
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SECTION I

GUIDELINES FOR INTERNAL QUALITY MONITORING PROGRAMS OF MANAGED CARE ORGANIZATIONS CONTRACTING WITH TENNCARE

Each Health Maintenance Organization (HMO) which contracts with TennCare (also referred to as the State) shall have in place an internal quality monitoring system. Internal Quality Monitoring programs (QMPs) consist of systematic activities, undertaken by the managed care organization itself to monitor and evaluate the care delivered to enrollees according to predetermined, objective standards, and to effect improvements as needed. The following guidelines will be used to establish State standards for internal QMPs for TennCare managed care contractors.

The guidelines were derived from three sources:

- The National Committee for Quality Assurance (NCQA) Quality Assurance Managed Care Organization Surveyor Guidelines, 2000;
- The National Association of HMO Regulators/National Association of Insurance Commissioners' Recommended Operational Requirements for HMO Quality Assurance Programs, adopted by the NAIC/NAHMOR Joint Task Force, December, 1988;
- The HCFA Office of Prepaid Health Care's Quality Assurance Standards for HMOs and CMPs Contraction with the Medicare Program, dated November, 1989;

as detailed in "A HEALTH CARE QUALITY IMPROVEMENT SYSTEM FOR MEDICAID COORDINATED CARE", U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, Health Care Financing Administration Medicaid Bureau, December 23, 1992.

SECTION I

GUIDELINES FOR INTERNAL QUALITY MONITORING PROGRAMS OF MANAGED CARE ORGANIZATIONS CONTRACTING WITH TENNCARE

STANDARD I: WRITTEN QMP DESCRIPTION

The organization has a written description of its QMP. This written description meets the following criteria:

- A. **Goals and Objectives** - The written description contains a detailed set of QM objectives which are developed annually and include a timetable for implementation and accomplishment.
- B. **Scope** -
 - 1. The scope of the QMP is comprehensive, addressing both the quality of clinical care and the quality of non-clinical aspects of service, such as and including: availability, accessibility, coordination, and continuity of care.
 - 2. The QMP methodology provides for review of the entire range of care provided by the organization, by assuring that all demographic groups, care settings, (e.g., inpatient, ambulatory, [including care provided in private practice offices] and home care), and types of services (e.g., preventive, primary, specialty care, and ancillary) are included in the scope of the review.
- C. **Specific Activities** - The written description specifies quality of care studies and other activities to be undertaken over a prescribed period of time, and methodologies and organizational arrangements to be used to accomplish them. Individuals responsible for the studies and other activities are clearly identified and are appropriate.
- D. **Continuous Activity** - The written description provides for continuous performance of the activities, including tracking of issues over time.
- E. **Provider Review** - The QMP provides for:
 - 1. Review by physicians and other health professionals of the process followed in the provision of health services; and
 - 2. Feedback to health professionals and organization staff regarding performance and patient results.
- F. **Focus on Health Outcomes** - The QMP methodology addresses health outcomes to the extent consistent with existing technology.

STANDARD II: SYSTEMATIC PROCESS OF QUALITY ASSESSMENT & IMPROVEMENT

The QMP objectively and systematically monitors and evaluates the quality and appropriateness of care and service to members, through quality of care studies and related activities, and pursues opportunities for improvement on an ongoing basis.

The QMP has written guidelines for its quality of care studies and related activities which include:

- A. **Specification of clinical or health services delivery areas to be monitored** -
 - 1. The monitoring and evaluation of care reflects the population served by the managed care organization in terms of age groups, disease categories, and special risk status.
 - 2. For the TennCare population, the QMP monitors and evaluates, at a minimum, care and services in certain priority areas of concern selected by the State. These may be taken from among those identified by the Health Care Financing Administration's (HCFA's) Medicaid Bureau, or other sources as deemed necessary by

TennCare.

3. At its discretion and/or as required by TennCare, the organization's QMP also monitors and evaluates other important aspects of care and services.

B. Use of Quality Indicators -

Quality indicators are measurable variables relating to a specified clinical or health services delivery area, which are reviewed over a period of time to monitor the process or outcomes of care delivered in that area.

1. The organization identifies and uses quality indicators including those specified in Attachment II that are objective, measurable, and based on current knowledge and clinical experience.
2. For the priority areas selected by the state from the HCFA Medicaid Bureau's list of priority clinical and health services delivery areas of concern, or other sources as deemed necessary by the State, the organization shall monitor and evaluate quality of care through studies which include, but are not limited to, the quality indicators also specified by the HCFA's Medicaid Bureau or by the State.
3. Methods and frequency of data collection are appropriate and sufficient to detect need for program change.

C. Use of Clinical Care Standards/Practice Guidelines -

1. The QMP studies and other activities monitor quality of care against clinical care or health service delivery standards or practice guidelines specified for each area identified in "STANDARD II, A," above.
2. The standards/guidelines are based on reasonable scientific evidence and are developed or reviewed by plan providers.
3. The standards/guidelines focus on the process and outcomes of health care delivery, as well as access to care.
4. A mechanism is in place for continuously updating the standards/guidelines.
5. The standards/guidelines shall be included in provider manuals developed for use by managed care providers or otherwise disseminated to providers as they are adopted.
6. The standards/guidelines address preventive health services.
7. Standards/guidelines are developed for the full spectrum of populations enrolled in the plan.
8. The QMP shall use these standards/guidelines to evaluate the quality of care provided by the managed care organization's providers, whether the providers are organized in groups, as individuals, as IPAs, or in combinations thereof.

D. Analysis of Clinical Care and Related Services -

1. Appropriate clinicians monitor and evaluate quality through review of individual cases where there are questions about care, and through studies analyzing patterns of clinical care and related services. For quality issues identified in the QMP's targeted clinical areas, the analysis includes the identified quality indicators and uses clinical care standards or practice guidelines.
2. Multidisciplinary teams are used, where indicated, to analyze and address systems issues.
3. From a. and b., clinical and related service areas requiring improvement are identified.

E. Implementation of Remedial/Corrective Actions -

The QMP includes written procedures for taking appropriate remedial action whenever, as determined under the QMP, inappropriate or substandard services are furnished, or services that should have been furnished were not.

These written remedial/corrective action procedures include:

1. specification of the types of problems requiring remedial/corrective action;
2. specification of the person(s) or body responsible for making the final determinations regarding quality problems;
3. specific actions to be taken;
4. provision of feedback to appropriate health professionals, providers and staff;
5. the schedule and accountability for implementing corrective actions;
6. the approach to modifying the corrective action if improvements do not occur;
7. procedures for terminating the affiliation with the physician, or other health professional or provider.

F. Assessment of Effectiveness of Corrective Actions -

1. As actions are taken to improve care, there is monitoring and evaluation of corrective actions to assure that appropriate changes have been made. In addition, changes in practice patterns are tracked.
2. The managed care organization assures follow-up on identified issues to ensure that actions for improvement have been effective.

G. Evaluation of Continuity and Effectiveness of the QMP -

1. The managed care organization conducts a regular examination of the scope and content of the QMP to ensure that it covers all types of services in all settings, as specified in STANDARD I-B-2.
2. At the end of each year, a written report on the QMP is prepared, which addresses: QM studies and other activities completed; trending of clinical and service indicators and other performance data; demonstrated improvements in quality; areas of deficiency and recommendations for corrective action; and an evaluation of the overall effectiveness of the QMP.
3. There is evidence that QM activities have contributed to reasonable improvements in the care delivered to members such that the level of care provided is that which is recognized as acceptable professional practice in the respective community in which particular providers practice.

STANDARD III: ACCOUNTABILITY TO THE GOVERNING BODY

The Governing Body of the organization is the Board of Directors or, where the Board's participation with quality improvement issues is not direct, a designated committee of the senior management of the managed care organization. Responsibilities of the Governing Body for monitoring, evaluating, and making improvements to care include:

- A. Oversight of QMP - There is documentation that the Governing Body has approved the overall QMP and an annual QM plan.
- B. Oversight Entity - The Governing Body has formally designated an accountable entity or entities within the organization to provide oversight of QM, or has formally decided to provide such oversight as a committee of the whole.

- C. QMP Progress Reports - The Governing Body routinely receives written reports from the QMP describing actions taken, progress in meeting QM objectives, and improvements made.
- D. Annual QMP Review - The Governing Body formally reviews on a periodic basis (but no less frequently than annually) a written report on the QMP which includes: studies undertaken, results, subsequent actions, and aggregate data on utilization and quality of services rendered, to assess acceptability.
- E. Program Modification - Upon receipt of regular written reports from the QMP delineating actions taken and improvements made, the Governing Body takes action when appropriate and directs that the operational QMP be modified on an ongoing basis to accommodate review findings and issues of concern within the organization. This activity is documented in the minutes of the meetings of the Governing Board in sufficient detail to demonstrate that it has directed and followed up on necessary actions pertaining to Quality Monitoring/Improvement.

STANDARD IV: ACTIVE QM COMMITTEE

The QMP delineates an identifiable structure responsible for performing QM functions within the organization. This committee or other structure has:

- A. Regular Meetings - The structure/committee meets on a regular basis with specified frequency to oversee QMP activities. This frequency is sufficient to demonstrate that the structure/committee is following-up on all findings and required actions, but in no case are such meetings less frequent than quarterly.
- B. Established parameters for Operating - The role, structure and function of the structure/committee are specified.
- C. Documentation - There are records documenting the structure's/committee's activities, findings, recommendations and actions.
- D. Accountability - The QMP committee is accountable to the Governing Body and reports to it (or its designee) on a scheduled basis on activities, findings, recommendations and actions.
- E. Membership - There is active participation in the QM committee from health plan providers, who are representative of the composition of the health plan's providers and shall include as a non-voting member, a representative of the TennCare Office of the Medical Director.

STANDARD V: QMP SUPERVISION

There is a designated senior executive who is responsible for program implementation. The organization's Medical Director has substantial involvement in QM activities.

STANDARD VI: ADEQUATE RESOURCES

The QMP has sufficient material resources, and staff with the necessary education, experience, or training, to effectively carry out its specified activities.

STANDARD VII: PROVIDER PARTICIPATION IN THE QMP

- A. Participating physicians and other providers are kept informed about the written QM plan.
- B. The organization includes in all its provider contracts and employment agreements; for both physicians and non-physician providers, a requirement securing cooperation with the QMP.
- C. Contracts specify that hospitals and other contractors will allow the managed care organization access to the medical records of its members.

STANDARD VIII: DELEGATION OF QMP ACTIVITIES

The organization remains accountable for all QMP functions, even if certain functions are delegated to other entities. If the managed care organization delegates any QM activities to contractors:

- A. There is a written description of: the delegated activities; the delegate's accountability for these activities; and the frequency of reporting to the managed care organization.
- B. The organization has written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care being provided.
- C. There is evidence of continuous and ongoing evaluation of delegated activities, including approval of quality improvement plans and regular specified reports.

STANDARD IX: CREDENTIALING AND RE-CREDENTIALING

The QMP contains the following provisions to determine whether physicians and other health care professionals, who are licensed by the State and who are under contract to the organization, are qualified to perform their services.

- A. **Written Policies and Procedures** - The managed care organization has written policies and procedures for the credentialing process, which includes the organization's initial credentialing of practitioners, as well as its subsequent re-credentialing, re-certifying and/or reappointment of practitioners.
- B. **Oversight by Governing Body** - The Governing Body, or the group or individual to which the Governing Body has formally delegated the credentialing function, has reviewed and approved the credentialing policies and procedures.
- C. **Credentialing Entity** - The plan designates a credentialing committee or other peer review body which makes recommendations regarding credentialing decisions.
- D. **Statewide Credentialing Verification Organization** - The CVO shall verify information to be used for credentialing and re-credentialing TennCare primary care providers and all other physicians (including specialists) in accordance with the applicable standards of the National Committee for Quality Assurance (NCQA) and TennCare. MCOs shall request information to be used for verification and re-verification of credentials from the MCO for primary care providers or other physicians, whom the MCO contemplates, will provide services to TennCare enrollees.
- E. **Scope** - The MCO shall identify those practitioners to be credentialed that fall under its scope of authority and action. Practitioners to be credentialed shall include, at a minimum, all physicians, dentists, and other licensed independent practitioners included in the review organizations' literature for members, as an indication of those practitioners whose service to members is contracted or anticipated. The MCO shall submit a plan to the TennCare Bureau outlining the process which it shall employ to ensure appropriate and timely credentialing of all providers participating in the health plan. The process employed to credential providers should address if information to be used to credential primary care providers and all other physicians shall be provided by the Statewide CVO, or if said providers will be credentialed by a large provider group(s) that has been delegated credentialing responsibilities or by the MCO, or its parent company, as a part of the credentialing process for a commercial line of business that accounts for at least fifty percent (50%) of the MCO's total business.
- F. **Process** - The initial credentialing process obtains and reviews verification of the following information, at a minimum:
 - 1. **Primary Verification**
 - a. the practitioner holds a current valid license to practice within the State;
 - b. valid DEA or CDS certificate, as applicable;

- c. confirmation of highest level of education and training received;
 - d. professional liability claims history (past five (5) years) from the National Practitioner Data Bank and the State Board of Medical Examiners; and
 - e. any sanctions imposed by Medicare, Medicaid and/or TennCare
2. Secondary Verification (self reported)
- a. work history – past five (5) years. Verbal explanation for gaps greater than six (6) months, written explanation for gaps greater than one (1) year;
 - b. good standing of clinical privileges at the hospital designated by the practitioner as the primary admitting facility; (This requirement may be waived for practices which do not have or do not need access to hospitals.)
 - c. the practitioner holds current, adequate malpractice insurance according to the plan's policy;
 - d. any revocation or suspension of a state license, DEA/BNDD number, or CDS certificate;
 - e. any curtailment or suspension of medical staff privileges (other than for incomplete medical records);
 - f. any censure by the State or County Medical Association;
 - g. the application process includes a statement by the applicant and an investigation of said statement regarding:
 - (1) any physical or mental health problems that may affect current ability to provide health care;
 - (2) any history of chemical dependency/substance abuse;
 - (3) history of loss of license and/or felony convictions;
 - (4) history of loss or limitation of privileges or disciplinary activity; and
 - (5) current malpractice coverage and limits; and
 - (6) an attestation to correctness/completeness of the application.

This information should be used to evaluate the practitioner's current ability to practice.

- 3. There is an initial visit to each potential primary care practitioner's office, including documentation of a structured review of the site and medical record keeping practices to ensure conformance with the managed care organization's standards.
- G. Recredentialing - A process for the periodic reverification of clinical credentials (recredentialing, reappointment, or recertification) is described in the organization's policies and procedures.
- 1. There is evidence that the procedure is implemented at least every three years..
 - 2. There is verification of State licensure at least every three years,
 - 3. The organization conducts periodic review of information from the National Practitioner Data Bank, along

with performance data, on all physicians, to decide whether to renew the participating physician agreement. At a minimum, the recredentialing, recertification or reappointment process is organized to verify current standing on items listed in "F-1" through "F-2.c" above, and item "F-2.g" as well.

4. The recredentialing, recertification or reappointment process also includes review of data from:
 - a. member complaints;
 - b. results of quality reviews;
 - c. utilization management;
 - d. member satisfaction surveys; and
 - e. reverification of hospital privileges and current licensure.

- H. Delegation of Credentialing Activities - The managed care organization may only delegate credentialing activities to large provider groups with 100 or more providers, unless otherwise approved by TennCare. If the managed care organization delegates credentialing (and recredentialing, recertification, or reappointment) activities, there must be a written description of the delegated activities, and the delegate's accountability for these activities. There must also be evidence that the delegate accomplished the credentialing activities. The managed care organization monitors the effectiveness of the delegate's credentialing and reappointment or recertification process

- I. Retention of Credentialing Authority - The managed care organization retains the right to approve new providers and sites, and to terminate or suspend individual providers. The organization has policies and procedures for the suspension, reduction or termination of practitioner privileges.

- J. Reporting Requirement - There is a mechanism for, and evidence of implementation of, the reporting of serious quality deficiencies resulting in suspension or termination of a practitioner, to the appropriate authorities.

- K. Appeals Process - There is a provider appellate process for instances where the managed care organization chooses to reduce, suspend or terminate a practitioner's privileges with the organization.

STANDARD X: ENROLLEE RIGHTS AND RESPONSIBILITIES

The organization demonstrates a commitment to treating members in a manner that acknowledges their rights and responsibilities.

- A. Written Policy on Enrollee Rights - The organization has a written policy that recognizes the following rights of members:
 1. to be treated with respect, and recognition of their dignity and need for privacy;
 2. to be provided with information about the organization, its services, the practitioners providing care, and members' rights and responsibilities;
 3. to be able to choose primary care practitioners, within the limits of the plan network, including the right to refuse care from specific practitioners;
 4. to participate in decision-making regarding their health care;
 5. to voice complaints or appeals about the organization or care provided;
 6. to formulate advance directives; and
 7. to have access to his/her medical records in accordance with applicable Federal and State laws.

- B. Written Policy on Enrollee Responsibilities - The organization has a written policy that addresses members' responsibility for cooperating with those providing health care services. This written policy addresses members' responsibility for:**
1. providing, to the extent possible, information needed by professional staff in caring for the member; and
 2. following instructions and guidelines given by those providing health care services.
- C. Communication of Policies to Providers - A copy of the organization's policies on members' rights and responsibilities is provided to all participating providers.**
- D. Communication of Policies to Enrollees/Members - Upon enrollment, members are provided a written statement that includes information on the following:**
1. rights and responsibilities of members;
 2. benefits and services included and excluded as a condition of membership, and how to obtain them, including a description of:
 - a. any special benefit provisions (for example, co-payment, higher deductibles, rejection of claim) that may apply to services obtained outside the system; and
 - b. the procedures for obtaining out-of-area coverage;
 3. provisions for after-hours and emergency coverage;
 4. the organization's policy on referrals for specialty care;
 5. charges to members, if applicable, including:
 - a. policy on payment of charges; and
 - b. co-payment and fees for which the member is responsible;
 6. procedures for notifying those members affected by the termination or change in any benefits, services, or service delivery office/site;
 7. procedures for appealing decisions adversely affecting the member's coverage, benefits, or relationship to the organization;
 8. procedures for changing practitioners;
 9. procedures for disenrollment; and
 10. procedures for voicing complaints and/or appeals and for recommending changes in policies and services.
- E. Enrollee/Member Complaint and Appeal Procedures - The organization has a system(s), linked to the QMP, for resolving members' complaints and appeals. This system includes:**
1. procedures for registering and responding to complaints and appeals in a timely fashion (organizations should establish and monitor standards for timeliness);
 2. documentation of the substance of complaints or appeals, and actions taken;
 3. procedures to ensure a resolution of the complaint or appeal;

4. aggregation and analysis of complaint and appeal data and use of the data for quality improvement; and
 5. an appeal process for adverse actions.
- F. Enrollee/Member Suggestions - Opportunity is provided for members to offer suggestions for changes in policies and procedures.
- G. Steps to Assure Accessibility of Services - The managed care organization takes steps to promote accessibility of services offered to members. These steps include:
1. the points of access to primary care, specialty care, and hospital services are identified for members; and
 2. at a minimum, members are given information about:
 - a. how to obtain services during regular hours of operations;
 - b. how to obtain emergency and after-hours care; and
 - c. how to obtain the names, qualifications, and titles of the professionals providing and/or responsible for their care.
- H. Written Information for Members -
1. Member information (for example, subscriber brochures, announcements, handbooks) is written in prose that is readable and easily understood.
 2. Written information is available, as needed, in the languages of the major population groups served. A "major" population group is one which represents at least 10 percent of a plan's population or 3,000 enrollees, whichever is less. All vital MCO documents and the member handbook is available in Spanish. All vital MCO documents are also available to Limited English Proficiency groups identified by TENNCARE that constitutes five percent (5%) of the TennCare population or 1,000 enrollees, whichever is less.
- I. Confidentiality of Patient Information - The organization acts to ensure that the confidentiality of specified patient information and records is protected.
1. The organization has established in writing, and enforced, policies and procedures on confidentiality, including confidentiality of medical records.
 2. The organization ensures that patient care offices/sites have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the medical care organization.
 3. The organization shall hold confidential all information obtained by its personnel about enrollees related to their examination, care and treatment and shall not divulge it without the enrollee's authorization, unless:
 - a. it is required by law;
 - b. it is necessary to coordinate the patient's care with physicians, hospitals, or other health care entities, or to coordinate insurance or other matters pertaining to payment; or
 - c. it is necessary in compelling circumstances to protect the health or safety of an individual.
 4. Any release of information in response to a court order is reported to the patient in a timely manner.

5. Enrollee records may be disclosed, whether or not authorized by the enrollee, to qualified personnel for the purpose of conducting scientific research, but these personnel may not identify, directly or indirectly, any individual enrollee in any report of the research or otherwise disclose participant identity in any manner.
- J. Treatment of Minors - The organization has written policies regarding the appropriate treatment of minors.
 - K. Assessment of Member Satisfaction - The organization conducts periodic surveys of member satisfaction with its services.
 1. The surveys include content on perceived problems in the quality, availability, and accessibility of care.
 2. The surveys assess at least a sample of:
 - a. all Medicaid members;
 - b. Medicaid member requests to change practitioners and/or facilities; and
 - c. disenrollment by Medicaid members.
 3. As a result of the surveys, the organization:
 - a. identifies and investigates sources of dissatisfaction;
 - b. outlines action steps to follow-up on the findings; and
 - c. informs practitioners and providers of assessment results.
 4. The organization reevaluates the effects of the above activities.

STANDARD XI: STANDARDS FOR AVAILABILITY AND ACCESSIBILITY -

The plan has established standards for access (e.g., to routine, urgent and emergency care; telephone appointments; advice; and member service lines). Performance on these dimensions of access are assessed against the standards.

STANDARD XII: STANDARDS FOR FACILITIES

- A. The organization maintains standards for facilities in which patients receive ambulatory care. These standards address:
 1. compliance with existing State and local laws regarding safety and accessibility;
 2. availability of emergency equipment;
 3. storage of drugs; and
 4. inventory control for expired medications.
- B. A requirement for adherence to these standards is contained in all of the organization's provider contracts.

STANDARD XIII: MEDICAL RECORD STANDARDS

- A. Accessibility and Availability of Medical Records -

1. The organization shall include provisions in provider contracts for appropriate access to the medical records of its enrollees for purposes of quality reviews conducted by the Secretary, TennCare agencies, or agents thereof.
 2. Records are available to health care practitioners at each encounter.
- B. Recordkeeping - Medical records may be on paper or electronic media. The Plan takes steps to promote maintenance of medical records in a legible, current, detailed, organized and comprehensive manner that permits effective patient care and quality review as follows:
1. Medical Record Standards - The organization sets standards for medical records. These standards shall, at a minimum, include requirements for:
 - a. Patient Identification Information - Each page in the record contains the patient's name or patient ID number.
 - b. Personal/biographical Data - Personal/biographical data includes: age; sex; address; employer; home and work telephone numbers; and marital status.
 - c. Entry Date - All entries are dated.
 - d. Provider Identification - All entries are identified as to author.
 - e. Legibility - The record is legible to someone other than the writer. Any record judged illegible by one physician reviewer should be evaluated by a second reviewer. If still illegible, it shall be considered deficient.
 - f. Allergies - Medication allergies and adverse reactions are prominently noted on the record. Absence of allergies (no known allergies - NKA) is noted in an easily recognizable location.
 - g. Past Medical History - (for patients seen three or more times) Past medical history is easily identified including serious accidents, operations, illnesses. For children, past medical history relates to prenatal care and birth.
 - h. Immunizations - (for pediatric records ages 12 and under) There is a completed immunization record or a notation that immunizations are up-to-date.
 - i. Diagnostic information.
 - j. Medication information.
 - k. Identification of current problems - Significant illnesses, medical conditions and health maintenance concerns are identified in the medical record.
 - l. Smoking/ETOH/Substance Abuse - (For patients 12 years and over and seen three or more times) Notation concerning cigarettes and alcohol use and substance abuse is present. Abbreviations and symbols may be appropriate.
 - m. Referrals and Results Thereof.
 - n. Emergency Care.
 - o. Hospital Discharge Summaries - Discharge summaries are included as part of the medical record for (1) all hospital admissions which occur while the patient is enrolled in the HMO; and (2) prior admissions as necessary.

- p. Advance Directive - The medical record documents whether or not the individual has executed an advance directive. An advance directive is a written instruction such as a living will or durable power of attorney for health care relating to the provision of health care when the individual is incapacitated.
2. Patient Visit Data - Documentation of individual encounters must provide adequate evidence of, at a minimum:
- a. History and Physical Examination - Appropriate subjective and objective information is obtained for the presenting complaints.
 - b. Plan of Treatment.
 - c. Diagnostic Tests.
 - d. Therapies and other Prescribed Regimens.
 - e. Follow-up - Encounter forms or notes have a notation, when indicated, concerning follow-up care, call or visit. Specific time to return is noted in weeks, months, or PRN. Unresolved problems from previous visits are addressed in subsequent visits.
 - f. Consultations, Referrals and Specialist Reports - Notes from any consultations are in the record. Consultation, lab and x-ray reports filed in the chart have the ordering physician's initials or other documentation signifying review. Consultation and significantly abnormal lab and imaging study results have an explicit notation in the record of follow-up plans.
 - g. All Other Aspects of Patient Care, Including Ancillary Services.
- C. Record Review Process -
- 1. The organization has a record review process to assess the content of medical records for legibility, organization, completion and conformance to its standards.
 - 2. The record assessment system addresses documentation of the items listed in B, above.

STANDARD XIV: UTILIZATION REVIEW -

- A. Written Program Description - The organization has a written utilization management program description which includes, at a minimum, procedures to evaluate medical necessity, criteria used, information sources and the process used to review and approve the provision of medical services.
- B. Scope - The program has mechanisms to detect underutilization as well as overutilization.
- C. Preauthorization and Concurrent Review Requirements - For organizations with preauthorization or concurrent review programs:
 - 1. The organization shall not employ, and shall not permit others acting on their behalf to employ utilization control guidelines or other quantitative coverage limits, whether explicit or defacto, unless supported by an individualized determination of medical necessity based upon the needs of each TennCare enrollee and his/her history.
 - 2. Preauthorization and concurrent review decisions are supervised by qualified medical professionals.
 - 3. Efforts are made to obtain all necessary information, including pertinent clinical information, and consult

with the treating physician as appropriate.

4. The reasons for decisions are clearly documented and available to the member.
5. There are well-publicized and readily available appeals mechanisms for both providers and patients.
6. Decisions and appeals are made in a timely manner as required by the exigencies of the situation.
7. There are mechanisms to evaluate the effects of the program using data on member satisfaction, provider satisfaction or other appropriate measures.
8. If the organization delegates responsibility for utilization management, it has mechanisms to ensure that these standards are met by the delegate.

STANDARD XV: CONTINUITY OF CARE SYSTEM

The organization has put a basic system in place which promotes continuity of care and case management. The organization shall report to TENNCARE, on a quarterly basis, the total number of enrollees and the percentage of total enrollees who have not been assigned to a primary care provider within thirty (30) days of enrollment .

STANDARD XVI: QMP DOCUMENTATION

- A. Scope - The organization shall document that it is monitoring the quality of care across all services and all treatment modalities, according to its written QMP.
- B. Maintenance and Availability of Documentation - The organization must maintain and make available to the State, and upon request to the Secretary, studies, reports, protocols, standards, worksheets, minutes, or such other documentation as may be appropriate, concerning its QM activities and corrective actions.

STANDARD XVII: COORDINATION OF QM ACTIVITY WITH OTHER MANAGEMENT ACTIVITY

The findings, conclusions, recommendations, actions taken, and results of the actions taken as a result of QM activity, are documented and reported to appropriate individuals within the organization and through the established QM channels.

- A. QM information is used in recertification, recontracting and/or annual performance evaluations.
- B. QM activities are coordinated with other performance monitoring activities, including utilization management, risk management, and resolution and monitoring of member complaints and grievances.
- C. There is a linkage between QM and the other management functions of the health plan such as:
 1. network changes;
 2. benefits redesign;
 3. medical management systems (e.g., precertification);
 4. practice feedback to physicians;
 5. patient education; and
 6. member services.

SECTION II

CLINICAL AND HEALTH SERVICES DELIVERY AREAS OF CONCERN, QUALITY INDICATORS, AND CLINICAL PRACTICE GUIDELINES FOR QUALITY IMPROVEMENT IN TENNCARE MANAGED CARE ORGANIZATIONS

I. INTRODUCTION

The section entitled "GUIDELINES FOR INTERNAL QUALITY MONITORING PROGRAMS OF MANAGED CARE ORGANIZATIONS CONTRACTING WITH THE TENNESSEE COMPREHENSIVE HEALTH INSURANCE PLAN" (the Guidelines) describes the activities which TennCare requires as standards for internal quality assurance programs (QMPs). The Guidelines, in part, call for coordinated care organizations to implement a systematic process of quality assessment and improvement by which the care delivered to enrollees is monitored, evaluated, and continually improved. The Guidelines further require that coordinated care organizations conduct quality of care studies which:

- A. target specific clinical conditions (e.g., pregnancy), and/or specific health services delivery issues (e.g., access to care) for focused monitoring and evaluation;
- B. use clinical care standards/practice guidelines to objectively evaluate the care the organization delivers (or fails to deliver) for the targeted clinical conditions and health services delivery issues; and
- C. use quality indicators derived from the clinical care standards/practice guidelines to screen and monitor care and services delivered.

This section provides further clarification as to how these three activities shall be implemented by managed care organizations in order to comply with the Guidelines for internal QMPs.

II. QUALITY OF CARE STUDIES

A managed care organization cannot monitor the care delivered to every enrollee each time he or she requires health care. Such an attempt would be beyond the organization's and State and Federal resources. As an alternative, the managed care organization shall select certain aspects of care to monitor over a specified time period. Over subsequent time periods, monitoring will be repeated in that area to detect patterns of care over time, and new areas will be selected for initial study. Such monitoring takes place through focused quality of care studies.

Focused quality of care studies are detailed investigations of certain aspects of health care services which are designed to answer defined questions about the quality and appropriateness of care and point the way to how that care can be improved. Such focused studies are superior to random or unfocused record reviews because they provide information about care in the aggregate as opposed to information about the care received by a limited number of enrollees.

A focused study may be conducted by reviewing medical records, by reviewing claims or other administrative data, by conducting special surveys, or other mechanisms. Whatever the source of information, all well designed studies have the following components:

- A. A clearly defined study question which focuses on relevant areas of concern in health care. Quality of care studies may be small and narrowly focused (e.g., "When are pregnant enrollees receiving their first prenatal care visits?"), or large and more complex (e.g., "What prenatal care factors are associated with enrollees delivering low birth weight babies?"). The clinical areas selected for study should reflect the coordinated care organization's enrollment in terms of demographic characteristics and the prevalence or risk of disease, and reflect the potential consequence of the (risk of) disease.

- B. Well defined items (clinical indicators) to be monitored and evaluated to help answer the question.
- C. A standard or standards against which the organization compares itself.
- D. A method for analyzing the results to indicate ways in which the organization can improve the care it delivers to enrollees.

III. CLINICAL AND HEALTH SERVICES DELIVERY AREAS OF CONCERN:

Item II. A. in the "Guidelines for Internal Quality Monitoring Programs of Managed Care Organizations Contracting with TennCare", states in part:

"The QMP has written guidelines for its quality of care studies...which shall include:

- 1. Specification of clinical or health services delivery area to be monitored -
 - a. The monitoring and evaluation of care reflects the population served by the managed care organization in terms of age groups, disease categories, and special risk status.
 - b. For the TennCare population, the QMP monitors and evaluates, at a minimum, care and services in certain priority areas of concern selected by the State. These may be taken from among those identified by HCFA's Medicaid Bureau, or other sources as deemed necessary by TennCare."

A review of the literature and discussion with health authorities pertaining to the prevalence and significance of health concerns has lead to the identification of the following priority clinical and health services delivery areas of concern. With the exception of the identification of pregnancy, childhood immunizations, and continuity of care, as required for continuous monitoring and evaluation by managed care plans, the areas listed below are not listed in any order of priority.

Clinical areas of concern:

- 1. Childhood Immunizations (Required continual monitoring with yearly reported)
- 2. Pregnancy (Required continual monitoring with yearly reporting)
- 3. Breast Cancer/Mammography
- 4. Cervical Cancer/Pap Smears
- 5. Lead Toxicity
- 6. Comprehensive Well Child Periodic Health Assessment
- 7. HIV Status
- 8. Asthma
- 9. Hysterectomies
- 10. Diabetes
- 11. ETOH and Other Substance Abuse
- 12. Hypertension

13. Sexually Transmitted Diseases
14. Heritable Diseases (Newborn screens)
15. Coronary Artery Disease
16. Motor Vehicle Accidents
17. Pregnancy prevention
18. Tuberculosis
19. Sickle Cell Anemia
20. Failure to Thrive
21. Hepatitis B
22. Otitis Media
23. Mental Health
24. Prescription Drug Abuse
25. Hip Fractures
26. Cholesterol Screening and Management
27. Treatment of Myocardial Infarctions
28. Prevention of Influenza
29. Smoking Prevention and Cessation
30. Medical Problems of the Frail Elderly; e.g., incontinence and confusion
31. Hearing and Vision Screening and Services for Individuals less than 21 Years of Age
32. Dental Screening and Services for Individuals less than 21 Years of Age and over 21 Years of Age

Health Services Delivery Areas of Concern:

1. Continuity/Coordination of Care (Required continual monitoring with quarterly reporting)
2. Access to Care
3. Utilization of Services
4. Health Education
5. Emergency Services

Two of the clinical areas of concern (childhood immunizations and pregnancy) and one of the health services delivery areas of concern (continuity/coordination of care) are required for continuous evaluation and study if applicable to the patient population. (enrollee Groups 3, 4, and 5 will not be considered applicable populations for the purpose of these studies). In addition, it is required that plans select on a

quarterly basis, at least one additional area of concern to study. This may be a follow-up of a previously performed evaluation or a new study. Areas of concern may come from the above noted list, or at the discretion of the organization, from another source. In addition, the organization will perform such studies as the State may direct. Effective July 1, 2001, all MCOs are required to begin a continuous evaluation and study of access to EPSDT services for individuals less than twenty-one (21) years of age. A copy of the study design shall be submitted to TENNCARE for review and approval within ninety (90) days of the effective date of this Agreement.

IV. CLINICAL PRACTICE GUIDELINES/STANDARDS:

The identification of areas needing improvement and the creation of a baseline for future assessment necessitates specifying goals or standards for health services to which care actually delivered can be compared. Item II. C. in the Guidelines states, in part, that:

- a. The QMP studies and other activities monitor quality of care against clinical care or health services delivery standards or practice guidelines specified for each clinical or health services delivery area identified in II. A., above..."

Clinical care standards, practice guidelines, practice options and practice advisories are all types of "practice parameters". Practice parameters are recommendations or an agreed upon set of principles for the delivery of certain types or aspects of health care. They are promulgated by authoritative bodies such as professional associations or ad-hoc "expert committees". Because professional judgement may often vary, there can frequently be more than one set of practice parameters addressing the same topic. However, the vast majority of medical professional organizations endorse the use of practice parameters in improving the quality of medical care.

For this reason, the Guidelines recommend monitoring quality of care using clinical care standards or practice guidelines for each clinical or health services delivery area selected by the organization or State for study. For the Federally recommended clinical areas of pregnancy and childhood immunizations, commonly accepted sources of guidelines are:

The American Academy of Pediatrics (AAP),

The U.S. Department of Health and Human Services' Public Health Service (PHS), and

The American College of Obstetricians and Gynecologists (ACOG)

For other clinical or health services delivery areas to be studied by the managed care organization as part of its agreement with TennCare, the coordinated care organization and TennCare shall agree upon the clinical practice standards or practice guidelines which are to be utilized by the organization in its evaluation of care. If TennCare wishes a coordinated care organization to evaluate care in an area in which the organization has not already adopted a set of practice guidelines, the organization and TennCare will agree upon usage of existing clinical practice standards/practice guidelines based upon those already developed by authoritative bodies.

V. QUALITY INDICATORS:

In conducting quality of care studies, the organization assesses care through the use of objective indicators. Quality indicators are measurable variables relating to a specified clinical or health services delivery area, which are reviewed over a period of time to screen delivered health care and/or to monitor the process or outcome of care delivered in that clinical area. Item II. B. of the Guidelines states:

- a. The organization identifies and uses quality indicators that are objective, measurable, and based on current knowledge and clinical experience.

- b. For the priority areas selected by the State from HCFA Medicaid Bureau's list of priority clinical and health services delivery areas of concern, or other sources as deemed necessary by the State, the organization shall monitor and evaluate quality of care through studies which include, but are not limited to, the quality indicators also specified by HCFA's Medicaid Bureau or the State."

TennCare and the managed care organization shall mutually determine clinical indicators to be monitored for each clinical or health services delivery area of concern. Because of their importance, childhood immunization indicators, pregnancy indicators, and continuity/coordination of care indicators shall be monitored by the organization on a continuous basis (as opposed to on a one time basis) and periodically (annually for immunization and pregnancy and quarterly for continuity/coordination of care) reported to TennCare. At its own discretion or as directed by TennCare, the organization should identify, based on clinical practice guidelines described above, additional clinical indicators to be monitored for the additionally selected clinical conditions.

In addition, TennCare shall use individual encounter data and other required reports to monitor performance on an on-going basis. Examples of the types of indicators TennCare will review related to the priority areas selected by the State (childhood immunizations, pregnancy and continuity of care) are noted below.

A. CHILDHOOD IMMUNIZATIONS

Clinical Indicators: For TennCare enrollees aged two, the annual immunization rates for polio (OPV), diphtheria-tetanus-pertussis (DPT), measles-mumps-rubella (MMR), haemophilus influenza B (HIB), and hepatitis B (HBV).

The Methodology for Monitoring and Reporting Indicators:

- 1. Identify all TennCare enrollees who were or attained two years of age in the twelve month review period and who were enrolled in the plan for at least six consecutive months of the 12 month review period.

Report this number: _____ and the dates of the 12 month review period: from _____ to _____.

- 2. Randomly sample and review the medical records or other immunization data source of the organization for at least one hundred of the above enrollees. For each enrollee, record the presence or absence of the full complement of required doses for each of the above immunizations according to the American Academy of Pediatrics or U.S. Center for Disease Control Advisory Committee on Immunization Practices' standards for immunizations prior to age two.
- 3. For each of the above immunizations, calculate the organization's rate of immunization as follows:

Polio immunizations:

Number of enrollees receiving all three polio immunization doses:

	<u>Number</u>	<u>Percent</u>
From plan:	_____	_____
By out-of-plan provider:	_____	_____

- b. The weeks of gestation on the date of the first prenatal care visit: _____. If date of delivery is date of first contact related to pregnancy, indicate as "no prenatal care."
- c. Number of prenatal care visits from and including the first prenatal care visit to and including the last visit prior to delivery: _____.
- d. Pregnancy outcome:
 - fetal loss (greater than or equal to 20 weeks) _____
 - live birth _____
- e. Birth weight for each live birth:
 - less than 500 Gms. _____
 - 500 - 1499 Gms. _____
 - 1500 - 2499 Gms. _____
 - greater than or equal to 2500 Gms. _____

C. CONTINUITY/COORDINATION OF CARE

The organization shall report the total number of enrollees and the percentage of enrollees in each Grand Region enrolled more than 30 days that have not identified a primary care provider (PCP) on a quarterly basis to the Office of the Medical Director. Primary care providers shall include licensed physicians as well as registered professional nurses and physician assistants practicing in accordance with state law. Each patient should have an identified primary care provider.

SECTION III

GUIDELINES FOR EXTERNAL QUALITY REVIEW OF RISK REIMBURSEMENT TENNCARE MANAGED CARE ORGANIZATIONS

I. INTRODUCTION:

Federal law (Section 1902(a)(30)(c) of the Social Security Act), requires entities which are external to and independent of the State and the coordinated care organization to perform, on an annual basis, a review of the quality of services furnished by each coordinated care contractor. Although this law specifies the types of entities which are allowed to perform this annual quality review, it does not prescribe how this quality review is to be conducted. This section specifies the scope of work for external quality review organization (EQRO) review of health care and services provided by managed care organizations to their TennCare enrollees.

II. PURPOSE:

The purpose of the external review function should be twofold:

TO PROVIDE THE STATE AND THE FEDERAL GOVERNMENT WITH AN INDEPENDENT ASSESSMENT OF THE QUALITY OF HEALTH CARE DELIVERED TO TennCare RECIPIENTS ENROLLED IN MANAGED CARE ORGANIZATIONS.

TO RESOLVE IDENTIFIED PROBLEMS IN HEALTH CARE AND CONTRIBUTE TO IMPROVING THE CARE OF ALL TennCare RECIPIENTS ENROLLED IN MANAGED CARE ORGANIZATIONS.

In order to accomplish these objectives, the information produced by the EQRO review should meet the following criteria:

- A. Information should accurately and reliably describe the care delivered to TennCare recipients. Information on quality of care obtained from the independent external review is a critical component of the TennCare Quality Improvement System (QIS) for coordinated care. If the QIS is to be effective in improving care, it must have accurate and reliable information upon which the State may take action to improve care. Therefore, reviews of care should be conducted in accordance with generally accepted principles of research design and statistical analysis in order to produce valid, reliable, and generalizable information.
- B. Information should have the largest possible impact on care. Because resources are finite, it is not possible to examine every episode of illness or every encounter with a provider for every TennCare enrollee. Therefore, the external quality review should give priority attention to clinical conditions or health services delivery issues:

which have highest prevalence or incidence; and
for which appropriate care has the greatest potential for improving health outcomes.
- C. Information should clearly identify instances in which care can be improved and provide a baseline for future assessment to see if care has actually been improved. The identification of areas needing improvement and the creation of a baseline for future assessment requires the advance specification of goals or standards for health services to which care actually delivered can be compared. The external quality review should measure care delivered against objective measures of health care which have been agreed upon by the TennCare, the EQRO, and, to the extent possible, the managed care organizations.

III. CONCEPTUAL APPROACH:

External Quality Review should include three types of activities:

1. focused studies of patterns of care;
2. individual case review in specific situations; and
3. follow-up activities on previous pattern of care study findings and individual case review findings.

Each of these activities is described below. The appropriate roles of TennCare agencies, EQROs and coordinated care organizations in carrying out these activities are discussed in Section IV, "Implementation".

A. Focused Pattern of Care Studies

Focused pattern of care studies are detailed investigations of certain aspects of care for specific clinical areas of interest (e.g., pregnancy, asthma, or immunizations), or for defined aspects of health services delivery which cut across clinical areas (e.g., access to care, utilization of services, continuity/coordination of care, health education or emergency services). Focused pattern of care studies contrast with random reviews of unrelated episodes or aspects of care. An example of a random review of unrelated episodes of care is: reviewing a subset or sample of the medical records of all enrollees to detect any problems in quality. Focused pattern of care studies are superior to random reviews, because they provide information about care in the aggregate as opposed to information on a limited number of cases. Information about care in the aggregate can be generalized to the care delivered at-large and thus can point the way to large scale change in care, as opposed to addressing quality on a case-by-case basis (as is done in random quality reviews).

Effective focused studies should meet the following criteria:

1. Selection of Study Topics - The clinical or health service delivery areas selected for study should reflect the distribution of health concerns within the TennCare population and should be of significant prevalence or incidence. Additionally, study topics should meet the following criteria:
 - a. There are objective criteria for assessing care in the clinical or health service delivery area to be monitored. These criteria should be derived from clinical practice/treatment guidelines which meet standards for practice guidelines contained in "Guidelines for Internal Quality Monitoring Programs of Managed Care Organizations Contracting with the Tennessee Comprehensive Health Insurance Program".
 - b. The study topic should be one in which there is likely to be opportunity to improve health status; for example, immunizations offer great opportunities to improve health status.
 - c. Study topics should not be restricted to care delivered in one type of setting; e.g., inpatient or ambulatory.
2. Study Design - Once the issues to be addressed through focused studies have been identified, the studies should be carefully designed if they are to produce information which is accurate, reliable, generalizable, and generally useful. To accomplish this, studies should be designed in accordance with generally accepted principles of scientific research and statistical analysis. The essential steps in study design are summarized here:

- a. Framing the Study Question - It is rarely possible to evaluate every aspect of care related to a specific clinical condition or health service delivery issue. Therefore, after each study topic involving a clinical condition or health service concern has been identified, the question each study is to answer must be refined. For example, if a plan has identified pregnancy as a clinical condition for study, there are numerous questions about quality of care that could be included in a full study. For example:
1. Did pregnant women receive prenatal care in accordance with certain specified clinical practice guidelines? What are the clinical practice guidelines against which care will be compared?
 2. Does the plan have a method for identifying "high-risk" pregnancies, and does it have established procedures for "high-risk" deliveries? Were these procedures appropriately used? What is the pattern of utilization of tertiary care facilities for childbirth?
 3. What are the characteristics of pregnant enrollees who delivered low birth weight babies, and how could the plan improve its service to these women?
 4. What are the nutritional and substance abuse characteristics of enrolled pregnant women? How could the plan improve its service to pregnant women based on the information obtained?

Information from enrollee satisfaction surveys, complaints, grievances, client disenrollments and State monitoring of plans may be utilized to assist in framing study questions. In addition, TennCare recipients or advocates can also play a role in determining issues to be studied as part of a particular study.

- b. Specifying Practice Guidelines for use in Assessing Care - When the EQRO monitors and evaluates care, it should compare the plan's performance against some concept of "good" care. What constitutes "good care" should be identified before data is obtained from plans about the health care it delivers. The TennCare document "Guidelines for Internal Quality Monitoring Programs of Managed Care Organizations Contracting with TennCare" calls for coordinated care organizations themselves to monitor and evaluate the care they deliver through the use of clinical practice guidelines acceptable to the State.

Practice guidelines, practice standards, practice advisories, or practice parameters are all terms used to refer to recommended "best practice" strategies for clinical decision making and patient care. Although the terminology may vary, all can serve as sources of quality indicators against which care delivered by the managed care organization can be assessed. This document uses the term "practice guidelines" although, for purposes of this document, any of these terms may be used interchangeably. Sources of practice guidelines may be found in the American Medical Association publication, "Directory of Practice Parameters", which is published annually, or may be identified from several other sources, including government and public health publications, recommendations from medical leadership and plan providers, as well as from published practice parameters.

Ideally, the practice guidelines which the managed care organization uses to assess care, and the guidelines used by the external review organization, should be identical. However, this may not always be the case. Regardless, the EQRO

shall review care in accordance with explicit guidelines approved by the State. If these guidelines are in conflict with those utilized for other purchasers of managed care services, this should be noted in the EQRO's analysis of findings and appropriately addressed.

- c. Defining and Quality Indicators that will be Monitored and Evaluated to Assess Care - From the practice guidelines, specific variables are derived to serve as indicators of the quality of care. These "quality indicators" are objective pieces of information that will be collected and analyzed to provide information to answer the study questions. For pregnancy, for example, selected quality indicators could include: birth weight, weeks of gestation at first prenatal visit, number of prenatal visits prior to delivery, or birth outcome (fetal loss of live birth).

Most quality indicators to be utilized will be "process of care" measures as opposed to outcome measures. If outcome indicators are considered, the difficulty of attributing outcome to health care received must be addressed, as well as the problem of the infrequent occurrence of some outcomes and the resulting problems of obtaining statistically significant results.

- d. Determining the Methodology which the EQRO will Utilize to Assess Care Delivered - The methodology to be utilized to compare care recommended in accordance with the identified practice guidelines should address the following:

1. What will be the sources of the data to be collected? Data can be obtained from many sources; e.g., medical records, administrative data, claims data, and survey data. Although the sources of data may vary by plan, the EQRO should attempt to use consistent data definitions and a consistent data collection methodology to promote comparability of data across plans. Abstraction instruments should be employed by the external review entity to aid in consistency of data collection, and data abstractors should be experienced in their use. This will promote internal validity and comparability across plans within a State.
2. Will sampling be utilized or will all incidents which meet study question criteria be included in the study? The methodology should estimate the prevalence of the issues under study within the plan. In plans with few TennCare enrollees or a small universe, it may be advisable to obtain data on all Medicaid enrollees instead of sampling. Where the universe is large, the external study should sample the condition under review.
3. If sampling is to be utilized, the sample should be derived in accordance with generally accepted principles of research design and statistical analysis in order to be appropriate to the purposes and hypotheses of the study. The sampling methodology and statistical analysis to be utilized should consider:
 - a. the intended uses of the data (e.g., does the State wish to make comparisons across plans or comparisons to regional or national data? Will it be used to sanction plans? Will it be released to the public at large?);
 - b. the nature of the data to be collected;

- c. the expected prevalence of compliance/noncompliance with certain guidelines;
 - d. the total number of studies to be conducted by the EQRO for each particular plan. Fewer studies with larger sample sizes and more numerous studies with smaller sample sizes may pose similar administrative burdens on plans. There are trade-offs to be made between the number of studies the State desires and the sample sizes that can reasonably be pursued for each study;
 - e. the degree of confidence required for the data.
4. Will there be continuous monitoring or one time collection of data? Is there a need for the State to have certain plan performance information more frequently than annually?
5. Determining the Methodology for Analysis of Results - The study methodology should specify:
- a. How the raw data collected from the study is to be verified.
 - b. What statistical analytical tests are to be performed on the data.
 - c. Whether the data analysis will be able to adjust for such influences as age, severity of illness, or other variables which may affect the findings for the study questions. If no adjustments are possible, this should be discussed in the report of external review study findings.
 - d. The performance measures to be used by the State to define "acceptable" performance by plans. For example, the State may choose to measure plan performance against national performance data, against the performance of other plans in the State, or through established "benchmarks" against which the plan will be expected to show continuous improvement.

If the State desires to utilize external quality review to make comparisons of the care given by different plans in the State, the external quality review analysis should contain descriptions of the varying sources and definitions of data collected across plans. If information is able to be collected from all plans in an identical manner and using identical definitions, plan comparisons should be more feasible. Where data collection and definitions are not identical, an explanation and discussion of the limitation on cross plan comparison based upon the different data sources and data definitions utilized by plans should be included in the external quality review report. Until there is national or State standardization of data definitions and data collection across plans, the ability to compare information across plans will be limited.

3. Analysis and Interpretation of Study Findings - Analysis of results is not limited to the performance of statistical tests upon the raw data. "Analysis" examines data in light of other knowledge about the study population, plans, and the environment in which plans and enrollees exist. Analysis attempts to produce "information" from "data". For example, when there is variation of plans from national norms, or variation between plans, what are likely explanations? Analysis of data should be conducted with input

from the plans and the State. It should produce recommendations for concrete actions which can be undertaken by plans, enrollees and the State to improve the health care received from coordinated care organizations.

B. Individual Case Reviews - As discussed above, population-based quality of care studies are more capable of providing generalizable quality of care information than are case-by-case reviews of care rendered to individuals. However, on occasion, there will also be a need for review of the quality of care delivered at the level of the individual. Such individual case review is necessary for individual incidents in which:

1. the occurrence is too infrequent to make judgements about "patterns" of care, or it is not possible to perform an analysis to detect "statistical" significance; or
2. the effect on an individual or individuals is so serious as to warrant individual attention.

Examples of clinical incidents which may warrant individual case review are: maternal death, childhood death (non-neonatal, trauma, immunologic or oncologic related), and ambulatory surgery deaths. Individual case review may also be appropriate in instances when questions are identified about a certain type of care provided by a particular provider. The State may further wish to reserve the right to refer a certain number of cases to the EQRO for individual case review on an ad-hoc basis when cases arise which do not fit into anticipated individual case review categories.

In individual case review, peer health care professionals from the EQRO should review the medical records and any other accessory information sources to determine: the anatomy of the incident; remedial action, if possible; steps which may be taken to prevent such an occurrence in the future; and the implications of this occurrence for the coordinated care organizations' quality assurance program and the State's quality improvement system. This information should be included in the EQRO's report to the State on plan performance in quality of health care and health care delivery.

C. Follow-up Activities on Study and Case Review Findings -

1. Both focused pattern of care studies and individual case review activities should result in formal written recommendations by the EQRO for actions to be undertaken by the plan, the State, or other parties (including the EQRO), as appropriate, to:
 - a. improve the care provided by the plan to TennCare recipients, and
 - b. resolve detected problems.
2. At the end of each review cycle, the EQRO should submit to the State a written report which contains: a description of its activities, pattern of care study findings, individual case review findings, and a Follow-Up Work Plan recommending activities to be conducted and the entities which are to conduct them to resolve identified problems and improve care overall. The work plan should include measurable goals so that problem resolution and care improvement can be objectively assessed. The work plan should be jointly developed by the EQRO and the organizations under review. (See Section IV, "Implementation", for greater discussion of this.)

In the subsequent review cycle the EQRO should conduct verification activities to determine two things:

- a. Were problem resolution and quality improvement activities implemented as recommended in the Follow-Up Work Plan?

- b. Have work plan activities achieved their stated goals?

Areas in which work plan goals have been reached would require no further follow-up (although the State may wish to continue to address these areas through focused studies or case review). Areas in which problem resolution or quality improvement goals were not reached will require both ongoing quality review and further follow-up activities. The EQRO should document organization compliance/non-compliance with recommendations.

IV. IMPLEMENTATION

There are a number of ways in which the working relationships between the State, the EQRO, and managed care organizations can be structured to implement the above approach to external quality review. The external quality review activity is more likely to be a successful Quality Improvement mechanism if the organizations under review are proactively involved in this quality improvement process. TennCare is committed to actively working with all of the involved entities to develop collaborative relationships for quality improvement. In designing the external quality review function and determining how it is to operate as part of the TennCare Quality Improvement System (QIS), the following issues shall be addressed:

A. Delineating the Role of the EQRO -

The EQRO is the contractor to the State. At a minimum, the EQRO is fully responsible for implementing quality review activities in accordance with certain specifications determined by the State. The EQRO may also have responsibilities for designing focused studies, individual case reviews and Follow-Up Work Plans.

The State will determine and specify the degree to EQRO involvement in the design of external quality review. The following design function will be explicitly addressed:

1. Selection of clinical conditions and/or health service delivery issues to be addressed through external quality review.
2. Study design features as described in the previous section, including: refining study questions, identification of practice guidelines to be used to assess care, identification of quality indicators, and determination of study methodology.
3. Analysis and Interpretation of study findings.
4. Determination of characteristics of cases to receive individual review.
5. Structuring of Follow-Up Work Plans.

B. Length of EQRO Contract with the State - The State will determine the length of the contract with EQRO.

C. Participation of Managed Care Organizations in Designing EQRO Review Activities -

Quality improvement and problem resolution activities will be most effective if the coordinated care organizations participate in their design. Participation by the organizations under review can contribute to improved quality review activities and quality of care in two ways:

1. Participation in quality review design will likely make implementation of the reviews easier for both the EQRO and the organization, and may increase the likelihood of being able to implement the review methodology as designed.

2. Advance knowledge of the scope of an intended review of care may encourage an organization to improve care in those areas prior to the review, thus improving care sooner rather than later.

To the extent possible, managed care organizations should participate in the following quality review design activities:

1. selection of clinical conditions and/or health service delivery issues to be addressed through external quality review;
2. study design features as described in the previous section, including: refining study questions, identification of practice guidelines to be used to assess care, identification of quality indicators, and determination of study methodology;
3. analysis and interpretation of study findings;
4. determination of characteristics of cases to receive individual review; and
5. structuring of Follow-Up Work Plans.

The above mentioned plan is not intended to prevent unannounced reviews either by the State or the EQRO of the managed care organizations. At a minimum, however, each plan shall be informed in advance, of the clinical practice guidelines which will be utilized in assessing care, and the quality indicators which will be reviewed by the State or the EQRO. Establishment of clinical practice guidelines should be done as far in advance of the review as possible.

- D. Potential Variation in the Type of Clinical Conditions/Health Services Delivery Issues to be Studied at Each Plan - In certain situations, the State may wish to vary the clinical conditions to be studied between plans. For example, the State may have different concerns for its inner city enrollees than for its rural enrollees.

- E. Determining the Number of Focused Pattern of Care Studies to be Conducted for Each Plan -

The number of studies to be conducted for each plan is, in part, a function of the methodology(ies) to be employed in conducting the quality of care studies. Complex studies need more resources than smaller studies; e.g., more data may need to be collected de novo from medical records rather than accessed from existing administrative data sets; data may need to be collected for consecutive years in order to obtain adequate sample sizes or detect trends in care; or the character of a certain condition may necessitate larger rather than smaller sample sizes.

The State may:

1. Require the same number of studies to be conducted by or for all plans. In this option the State has the option of requiring the EQRO to review different study issues for certain plans.
2. Require fewer studies from plans which have a strong history of producing information of high reliability and accuracy, and which have consistently shown compliance with agreed upon performance measures. The State would then direct the EQRO to perform or oversee a greater number of clinical studies in plans which have poorer quality of care performance in comparison to their counterparts.

Determination of the number and complexity of studies will be made by the State in consultation with the external quality review organization and the coordinated care plans.

- F. Methods for Implementing Focused Studies -

Because of the varying capabilities of plans to provide quality of care data and to conduct pattern of care studies, the TennCare may elect, at its discretion, any of three different approaches to utilizing the EQRO to obtain accurate pattern of care information from plans. The variation in these approaches is intended to provide flexibility to the State and plans in obtaining and providing external quality review information. The State may utilize different approaches for different managed care organizations depending upon the State's knowledge about each organization's past performance in the provision of health care and in the implementation of quality of care studies.

Option 1. EQRO Review of an Organization-Designed and Conducted Internal Study - THIS OPTION ASSUMES THE INDEPENDENT CAPABILITY OF THE COORDINATED CARE ORGANIZATION TO DESIGN AND IMPLEMENT A STUDY WHICH MEETS STATE SPECIFIED PARAMETERS. Under this option, the role of the EQRO is to review the coordinated care organizations' study to determine if the study methodology is valid and to perform an independent validity check of the internal study findings. If the external review organization's review supports the plan's methods and findings, then the external review organization can utilize the coordinated care organization's study findings in its report of plan performance to the State. If the external review organization finds that either than plan has not conducted a validly designed study which can answer the study questions, or that the study findings are not supported by an external validity check, then the external review organization can either impose a study methodology on the plan in accordance with Option 2, below, or conduct its own study (Option 3).

At a minimum, EQRO review of a managed care organization's internal study, should assess the following issues:

Was the study questions of the plan the same as that specified by the State? If not, did the study generate the proscribed study variables defined according to the same specifications to be used for the EQRO's study?

Was the collection of the same defined performance measures performed in a manner that preserves internal and external validity; e.g., Was the sampling methodology? Were reliable data collection mechanisms employed? Was it designed in accordance with generally accepted research principles?

Does a verification subsample confirm the findings of the plan?

Based upon the EQRO's evaluation of the plan's internal study, if the plan has conducted its internal study in an acceptable manner, then the State may exempt the organization from a full external study of this question and utilize data provided by the plan through its internal QMP.

Option 2. EQRO Design of Study/Implementation by Coordinated Care Organization - IN ADDITION TO SECURING THE QUALITY OF CARE INFORMATION SOUGHT BY THE STATE, THIS APPROACH HAS A SECONDARY DESIRABLE EFFECT OF IMPROVING THE INTERNAL QUALITY MONITORING CAPABILITY OF THE PLAN.

A coordinated care organization may not have sufficient resources or expertise to independently and competently design a focused pattern of care study which meets the criteria determined by the State. In such a situation, if the organization is willing to implement a quality assurance study in accordance with study design specifications established by the EQRO and the State, the EQRO may provide the organization with study design specifications to enable the organization to conduct its own internal study to meet State specifications. In this option, the EQRO and the organization would work collaboratively to develop study design specifications for the plan which meet study specifications established by the EQRO and State for the external quality reviews. The organization is then responsible for implementing the study in accordance with these

specifications. At the conclusion of the implementation of the study, the EQRO would perform the same evaluation of the plan's focused pattern of care study as it does for studies independently designed and conducted by managed care organizations as in Option 1, above. If the study meets all requirements, the EQRO may utilize this data in its plan performance report to the State.

If the plan is not willing to accept such guidance, or if the plan's study fails to meet criteria for acceptable performance, then the EQRO will both design and implement quality of care studies as in Option 3, below.

Option 3. Design and Implementation of Focused Studies Solely by the EQRO.

If the State determines, with input from the EQRO, that a review of the plan's internal studies is not feasible, or that an effort at having a coordinated care organization implement a study in accordance with State/EQRO specifications is not likely to be successful, the external quality review organization shall implement quality of care studies to answer the State's areas of concern in accordance with the conceptual model discussed in Part III above. In this option the role of the coordinated care organization shall be to provide or allow access to clinical or health services data required by the EQRO. This data may be in the form of medical records or data from administrative or other data sets. If information is obtained from sources other than medical records, the EQRO shall also perform a verification of the accuracy of the data base.

G. Individual Case Review - Since focused pattern of care studies generate information of greatest utility for quality improvement, and case-by-case review consumes more resources on a per-case basis, individual case review should be reserved for unique clinical care situations which meet either of the two criteria described in Part III:

1. the occurrence is too infrequent to make judgements about "patterns" of care or perform analyses to detect "statistical" significance; or
2. the effect on an individual or individuals is so serious as to warrant individual attention.

The State is responsible for identifying the criteria for selecting individual cases which will receive individual quality review. Because individual case review should be undertaken in very few cases, it is appropriate that it be well targeted. As with the process for external review overall, the effectiveness of targeting cases for individual case review process is likely to be most effective if designed jointly by the EQRO and the State, with input from the managed care organizations.

EQRO statisticians may be helpful in identifying clinical conditions or events which happen so rarely that pattern of care studies are not feasible. Managed care organizations may be helpful in identifying clinical or health services delivery incidents which warrant individual attention. The State may also utilize information from grievances and State monitoring plans to identify incidents which require individual case review. The State may also, at its discretion, direct that a particular case or cases be referred to the EQRO for individual case review.

H. Follow-Up Activities

After the EQRO has completed its focused studies and individual case reviews for each plan, it will produce a set of preliminary findings and recommendation for: problem resolution, quality improvement, and follow-up activities. These should be reviewed and commented upon jointly by plans and the State before being finalized. The State has the discretion to determine how and when this review is to take place. The State may choose to take any degree of involvement it desires in this process. The examples listed below should be considered as a continuum of involvement.

Example 1: High Level of TennCare Involvement - TennCare could require the EQRO to submit its preliminary findings directly to TennCare. TennCare would then take total responsibility for

reviewing the findings with coordinated care plans and developing a final report and follow-up work plan to be implemented by the EQRO.

Example 2: Low Level of TennCare Involvement - TennCare could direct the EQRO to meet with each plan it reviewed to present its findings to the plan and develop a mutually agreed upon problem resolution, quality improvement, and follow-up work plan. The EQRO would then submit a final report to the State.

Example 3: Midlevel TennCare Involvement - TennCare may direct the EQRO to implement a process for organization review and comment prior to finalizing the EQRO's annual report to the State. The process could be jointly developed and implemented by TennCare and the EQRO.

It is necessary to have the review of preliminary findings by the plans in order to assist in:

the interpretation of the quantitative findings of the EQRO; and

the development of follow-up plans for problem resolution and quality improvement.

Regardless of the degree of involvement of the TennCare in finalizing the preliminary findings of the EQRO, TennCare will be highly involved in the follow-up of the final findings of the annual EQRO quality review. TennCare will meet its responsibility to remain aware of: the quality of care provided by its coordinated care contractors; and necessary follow-up activities to be taken by the EQRO; or the status of the EQRO's implementation of follow-up activities. The EQRO will submit status reports every four to six months to TennCare on its follow-up activities on the preceding year's findings. In instances where a coordinated care organization's quality of care has shown significant deficiencies, TennCare will consider the appropriateness and applicability of intermediate sanctions.

V. CONFIDENTIALITY AND DISCLOSURE OF INFORMATION

TennCare will make clear to both the EQRO and coordinated care organizations how the TennCare will utilize information obtained from the reviews in any planned release of data, report of quality review findings, or requests for information from other public or private entities. TennCare will delineate what, if any, authority the EQRO has to release any plan specific or aggregate data other than information specific to a coordinated care organization to that same organization. If TennCare contracts with a Medicare Peer Review Organization (PRO) to conduct external quality reviews, the disclosure of external review information is governed by Section 1160 of the Social Security Act, "Protection Against Disclosure of Information." If TennCare uses an entity other than a PRO, disclosure of information is governed by State law and the confidentiality and data requirements of TennCare.

VI. SPECIFICATIONS FOR EXTERNAL QUALITY REVIEW ORGANIZATIONS

The external quality review process is based on a reliance on scientific principles governing research design and statistical analysis. In addition, the focus of the reviews is on health care services and on the delivery of these services. Because of this, the organization which conducts the reviews shall have personnel who are educated and experienced in the conduct of health services research and the provision of medical services. Further, the EQRO shall provide these individuals with appropriate supervision in the conduct of their work. At a minimum, EQROs shall have personnel with the following competencies:

A. Clinical Expertise -

The EQRO may utilize staff level personnel with varying clinical experience; e.g., medical, nursing, dental or other allied health professions. However, because the EQRO will be making measurements and assessments of the delivery of medical and related health services, clinical assessment activities undertaken by the EQRO shall be under the supervision of an individual with the appropriate education and experience in:

1. Assessing broad-based medical and other health care services, through the use of quality assurance technology such as: practice guidelines, quality indicators, and performance measures.
2. Utilizing practice guidelines - their development, evaluation and implementation.
3. Designing, implementing and assessing the effectiveness of corrective action plans/quality improvement activities.

In addition, the EQRO shall demonstrate that it has access to medical and health care experts in specific health care areas; e.g., specialty care, on an ad-hoc basis.

B. Health Services Research Expertise -

Because the primary activities to be undertaken by EQROs are designing, assessing and implementing focused quality of care studies, the EQRO shall have sufficient expertise in research methodology and statistical analytical methods to know how to undertake these activities and to instruct coordinated care organizations, as necessary, where a coordinated care organization wishes to undertake studies itself. EQROs shall have sufficient personnel resources in research and statistical analytical methods in order to provide assistance to coordinated care organizations and assess the soundness of focused quality of care studies on a timely basis.

SECTION IV

MONITORING MANAGED CARE

I. INTRODUCTION

Managed Care is intended to mean the proper utilization of available resources to achieve and maintain the highest degree of health and functional capability practically obtainable by an individual. This entails the provision of health care in such a way as to prevent those illnesses and conditions for which recognized preventive strategies have been shown to be possible and cost effective.

In the achievement of these goals however, the temptation to compromise the quality, availability and accessibility of services must be avoided. Especially important is the aspect of under-utilization in MCOs that are at financial risk of medically necessary services in order to reduce cost and increase the profitability of the provider and over-utilization of MCOs that are not at financial risk. There are a number of parameters which can and should be continually monitored to assure the provision of quality health care to every enrollee. Some of these examples follow this introduction.

II. ACCESS TO CARE

1. Managed Care organizations will be required to assure that the TennCare enrollee has access to care which meets the requirements of this Agreement.
2. TennCare will monitor access to primary care by reviewing the MCO provider network in the following primary care areas: Family Practice, Internal Medicine, Pediatrics, Obstetrics and Gynecology. TennCare will review the data from the MCO's monthly provider file that is electronically submitted to TennCare and compare this data with the MCO's membership to determine the numbers and distribution of providers compared to enrollees and to calculate travel distances between contracted providers and enrollees.
3. TennCare will monitor access to essential hospital services and Centers of Excellence by reviewing the "Essential Hospital Service Chart" and comparing this data with the MCO's membership to determine the geographic distribution of providers compared to enrollees calculating travel distances between contracted providers and enrollees.
4. TennCare will monitor access to care for Physician Specialty Services by reviewing the MCO's provider network, including non-contractual relationships, for physician specialties indicated in Section 2-4.1. TennCare will review the data from the MCO's monthly provider file that is electronically submitted to TennCare along with the CONTRACTOR's Physician Specialty charts for each specialty in each CRA. TennCare will assess this network in conjunction with the MCO's membership to determine the numbers and distribution of providers compared to enrollees and to calculate travel distances between providers and enrollees. TennCare will also compare physician specialty networks across MCOs serving the same regions to assist in identifying usual and customary referral patterns. TennCare will not necessarily require a CONTRACTOR to contract for all physician specialties within the same CSA that the enrollee resides, but will require the CONTRACTOR to establish provider agreements with each of the eleven physician specialists identified in Section 2-4.1 in each area designated by TennCare as a focal point for specialist services in the CONTRACTOR's service area. A sufficient number of provider agreements shall be established in each focal point to ensure that non-dual enrollee to provider ratios remain below the maximum allowable ratios for each area as defined in Attachment IV. TennCare will also review complaints and appeals to identify potential deficiencies in the CONTRACTOR's physician specialty services arrangements.
5. Member satisfaction surveys will be conducted by TennCare, independent of the CONTRACTOR. These surveys may include, availability of appointments, length of waiting times, office hours, ease of obtaining preventive medicine services, prescription medication coverage, the ability to obtain emergency services; the ability to obtain specialty services and any other services or conditions TennCare chooses to evaluate.

6. Provider surveys will be conducted by TennCare, independent of the CONTRACTOR. These surveys may include ease of requesting prior authorization, ease of obtaining specialty services referrals, and timeliness of claims payment processes.

III. STANDARDS OF CARE

1. Standards of care shall be taken from published recommendations of nationally recognized authorities such as; The American Medical Association; The American Dental Association, The American Academy of Pediatrics and the many other specialty and non-specialty groups. The standard of care for the community will also be recognized. Two examples of the types of standards which might be applied are listed here. Information on the monitoring of these standards may be found under **Quality of Care Monitors**.
2. Prenatal Care will be delivered according to standards of the American College of Obstetricians and Gynecologists (ACOG).
3. Child Health Care will be delivered according to the standards of the American Academy of Pediatrics (AAP) and in compliance with the EPSDT policies now in effect.

IV. QUALITY OF CARE MONITORS

1. Quality of Care will be monitored in an on-going manner by TennCare staff.
2. Managed Care organizations will be required to establish a Quality Improvement Unit to review inpatient and outpatient care provided by the organization.
3. Managed Care organizations will be required to establish a PEER review committee to monitor Quality of Care issues. This committee will have a clear and concise chain of command.
4. The PEER review committee will be responsible for directly addressing issues of concern by letter and face-to-face with the responsible provider.
5. The Managed Care organization shall immediately report to TennCare all cases of suspected provider or recipient fraud or abuse.
6. TennCare and/or it's agent shall be provided immediate access to medical and other patient related records by the Managed Care organization or it's employee providers of service, or it's contract providers of service.
7. TennCare and/or it's agent shall make unannounced visits either on a random basis or for a specific reason, to review medical and other patient related records.
8. The Managed Care organization shall immediately notify Medicaid of any malpractice actions brought against any of it's providers.
9. TennCare shall monitor MCO progress toward obtaining the benchmark level of performance for each of the measures specified below. The CONTRACTOR shall demonstrate meaningful improvement each year. Meaningful improvement is defined as ten (10) percentage point improvement over the prior years rate or satisfaction of the benchmark. The CONTRACTOR shall not be required to develop and analyze performance indicators for enrollees in Groups 3, 4, or 5 as defined in Section 4 of this Agreement. The performance indicators are:

Performance Indicator	Data Sources	Measure	Target	Benchmark
Childhood Immunizations	MCO encounter data; TennCare enrollment data	percentage of two-year old children receive all 12 recommended vaccines	100% of children immunized	To be determined.
Adolescent Immunizations	MCO encounter data ;TennCare Enrollment data	percentage of enrolled adolescents (who turn 13 during measurement year) receive recommended vaccines	100% of adolescents immunized	To be determined.
Checkups After Delivery	MCO encounter data ;TennCare enrollment data	percentage of female enrollees receive a post partum checkup 3-8 weeks after delivery	100% of women that delivery receive a check-up	To be determined.
Cervical Cancer Screening	MCO encounter data; TennCare enrollment data	percentage of enrolled women (ages 21-64) receive one or more pap tests in the reporting year or the two years prior to the reporting year	According to ACOG guidelines	To be determined.
Breast Cancer Screening	MCO encounter data; TennCare enrollment data	percentage of enrolled women who received a mammogram in the past two years	According to ACOG guidelines	To be determined.

Performance Indicator	Data Sources	Measure	Target	Benchmark
HBA1c Testing	MCO encounter data; TennCare enrollment data	percentage of members age 18 through 75 with one or more tests conducted during the measurement year. Notation in the medical record of any one of the following is acceptable: - Glycated hemoglobin - Glycosylated hemoglobin A1c - Glyco hemoglobin A1c - HBA1c hemoglobin A1c	At least one test each year	To be determined .
EPSDT	MCO encounter data; TennCare enrollment data	The percentage of children who received a periodic screen including all components (consistent with EPSDT Consent Decree Definition)	100% screening	Adjusted periodic screening percentage greater than 80%

For the purpose of monitoring Quality of Care, Access to Care and Availability of Care, TennCare shall routinely review vital records, birth records, individual encounter data, monthly provider files and other required reports to monitor quality of care and other available sources. TennCare may use individual encounter data, monthly provider files and other required reports to measure the Managed Care Organization's compliance with Provider Network, Claims Processing, Financial/Actuarial Stability, Clinical/Quality and Member/Provider Service standards.

ATTACHMENT III - TERMS AND CONDITIONS FOR ACCESS

ATTACHMENT III

Terms and Conditions for Access

In general, contractors shall provide available, accessible, and adequate numbers of institutional facilities, service locations, service sites, professional, allied, and paramedical personnel for the provision of covered services, including all emergency services, on a 24-hour-a-day, 7-day-a-week basis. At a minimum, this shall include:

- Primary Care Physician or Extender:
 - (a) Distance/Time Rural: 30 miles or 30 minutes
 - (b) Distance/Time Urban: 20 miles or 30 minutes
 - (c) Patient Load: 2,500 or less for physician; one-half this for a physician extender.
 - (d) Appointment/Waiting Times: Usual and customary practice (see definition below), not to exceed 3 weeks from date of a patient's request for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.
 - (e) Documentation/Tracking requirements:
 - + Documentation - Plans must have a system in place to document appointment scheduling times. The State must utilize statistically valid sampling methods for monitoring compliance with appointment/waiting time standards as part of the survey required in special term and condition 3.
 - + Tracking - Plans must have a system in place to document the exchange of client information if a provider, other than the primary care provider (i.e., school-based clinic or health department clinic), provides health care.
- Specialty Care and Emergency Care: Referral appointments to specialists (e.g., specialty physician services, hospice care, home health care, substance abuse treatment, rehabilitation services, etc.) shall not exceed 30 days for routine care or 48 hours for urgent care. All emergency care is immediate, at the nearest facility available, regardless of contract. Waiting times shall not exceed 45 minutes.
- Hospitals
 - (a) Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where access time may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented to the State on the basis of community standards.
- General Dental Services:
 - (a) Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where community standards and documentation will apply.
 - (b) Appointment/Waiting Times: Usual and customary not to exceed 3 weeks for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.
- General Optometry Services:
 - (a) Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where community standards and documentation shall apply.
 - (b) Appointment/Waiting Times: Usual and customary not to exceed 3 weeks for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.

- Pharmacy Services:
 - (a) Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where community access standards and documentation will apply.
- Lab and X-Ray Services:
 - (a) Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where community access standards and documentation will apply.
 - (b) Appointment/Waiting Times: Usual and customary not to exceed 3 weeks for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.
- All other services not specified here shall meet the usual and customary standards for the community.

Definition of "Usual and Customary" - access that is equal to or greater than the currently existing practice in the fee-for-service system.

Guidelines for State Monitoring of Plans

- State will require, by contract, that Plans meet certain State-specified standards for Internal Quality Assurance Programs (QAPs) as required in 42 CFR 434.

State will monitor, on a periodic or continuous basis (but no less often than every 12 months), Plans adherence to these standards, through the following mechanisms: review of each plan's written QAP, review of numerical data and/or narrative reports describing clinical and related information on health services and outcomes, and on-site monitoring of the implementation of the QAP standards.

- Recipient access to care will be monitored through the following State activities: periodic comparison of the number and types of providers before and after the waiver, periodic surveys which contain questions concerning recipient access to services, measurement of waiting periods to obtain health care services, and measurement of referral rates to specialists.

Guidelines for Plan Monitoring of Providers

- Plans will require, by contract, that providers meet specified standards as required by the State contract.
- Plans will monitor, on a periodic or continuous basis, providers' adherence to these standards, and recipient access to care.

ATTACHMENT IV - SPECIALTY NETWORK STANDARDS

ATTACHMENT IV Specialty Network Standards

For the purpose of assessing specialty provider network adequacy, TennCare MCO networks will be evaluated relative to the requirements described below. The purpose of these requirements is to ensure access and availability to specialists for non-dual Medicare/Medicaid eligibles while recognizing the actual disbursement and number of specialty resources available within the state. A provider is considered a "specialist" if he/she has a provider agreement with the MCO to provide specialty services to enrollees.

Access to Specialty Care

Contractors shall ensure access to specialists for the provision of covered services. This requirement shall be satisfied through the execution and maintenance of at least one provider agreement for the provision of each of the following types of specialist services in the area specified. This requirement ensures that TennCare enrollees in all MCOs will be able to access specialists within the community in which they reside or as close to it as feasible, while recognizing the constraints introduced by the limited availability of specialists in some areas.

The geographic areas, or "focal points" where contracts are required include Davidson, Hamilton, Knox, Madison, Maury, Putnam and Cumberland (Either one), Shelby, and Sullivan and Washington (Either one) counties, either because these are population centers or there is a major medical center located in the area. If MCOs establish contracts for the provision of specialty services in each of these eight focal points all TennCare enrollees will have access to specialists within a maximum travel distance of 90 miles, and the majority will have access to specialists within 60-miles. Contracts are required in these specific areas in recognition of traditional specialty referral patterns.

The areas in which MCOs are required to establish contracts are indicated in the chart below by Grand Region. Based on these requirements, an MCO serving the East Grand Region would be required to have at least three Cardiologists in its network (one in Hamilton, One in Knox, and one in Sullivan or Washington counties).

SPECIALIST	GRAND REGION		
	WEST	MIDDLE	EAST
Cardiology	<ul style="list-style-type: none"> ▪ Madison ▪ Shelby 	<ul style="list-style-type: none"> ▪ Davidson ▪ Putnam/Cumberland ▪ Maury 	<ul style="list-style-type: none"> ▪ Hamilton ▪ Knox ▪ Sullivan/Washington
ENT	<ul style="list-style-type: none"> ▪ Madison ▪ Shelby 	<ul style="list-style-type: none"> ▪ Davidson ▪ Putnam/Cumberland ▪ Maury 	<ul style="list-style-type: none"> ▪ Hamilton ▪ Knox ▪ Sullivan/Washington
Gastroenterology	<ul style="list-style-type: none"> ▪ Madison ▪ Shelby 	<ul style="list-style-type: none"> ▪ Davidson ▪ Putnam/Cumberland* ▪ Maury* 	<ul style="list-style-type: none"> ▪ Hamilton ▪ Knox ▪ Sullivan/Washington
Neurology	<ul style="list-style-type: none"> ▪ Madison ▪ Shelby 	<ul style="list-style-type: none"> ▪ Davidson ▪ Putnam/Cumberland* ▪ Maury* 	<ul style="list-style-type: none"> ▪ Hamilton ▪ Knox ▪ Sullivan/Washington
Neurosurgery	<ul style="list-style-type: none"> ▪ Shelby <p>Not Applicable to Madison</p>	<ul style="list-style-type: none"> ▪ Davidson <p>Not Applicable to Putnam/Cumberland and Maury</p>	<ul style="list-style-type: none"> ▪ Hamilton ▪ Knox <p>Not Applicable to Sullivan/Washington</p>
Oncology	<ul style="list-style-type: none"> ▪ Madison ▪ Shelby 	<ul style="list-style-type: none"> ▪ Davidson ▪ Putnam/Cumberland* ▪ Maury* 	<ul style="list-style-type: none"> ▪ Hamilton ▪ Knox ▪ Sullivan/Washington

SPECIALIST	GRAND REGION		
	WEST	MIDDLE	EAST
Ophthalmology	<ul style="list-style-type: none"> ▪ Madison ▪ Shelby 	<ul style="list-style-type: none"> ▪ Davidson ▪ Putnam/Cumberland ▪ Maury 	<ul style="list-style-type: none"> ▪ Hamilton ▪ Knox ▪ Sullivan/Washington
Orthopedics	<ul style="list-style-type: none"> ▪ Madison ▪ Shelby 	<ul style="list-style-type: none"> ▪ Davidson ▪ Putnam/Cumberland ▪ Maury 	<ul style="list-style-type: none"> ▪ Hamilton ▪ Knox ▪ Sullivan/Washington
Urology	<ul style="list-style-type: none"> ▪ Madison ▪ Shelby 	<ul style="list-style-type: none"> ▪ Davidson ▪ Putnam/Cumberland ▪ Maury* 	<ul style="list-style-type: none"> ▪ Hamilton ▪ Knox ▪ Sullivan/Washington

*Contract requirement waived for network approval in year 1 if documentation of attempts to contract and corrective action plan describing how services will be provided submitted to TennCare for prior approval.

Availability of Specialty Care

Contractors shall provide adequate numbers of specialists for the provision of covered services to ensure adequate provider availability. To account for variances in MCO enrollment size, the guidelines described in this section have been established for determining how many of each type of specialist an MCO must have. These are aggregate guidelines and are not age specific. To determine these guidelines the number of providers within each of the focal points in each Grand Region was compared to the size of the population in each Grand Region. The "area" being served includes the population of surrounding counties. The chart below provides the mapping of counties to focal points.

MCOs must comply with the following guidelines: MCOs must have at least one provider agreement with each specialist in each required area; and, MCOs must have a sufficient number of provider agreements to ensure that the number of enrollees per provider does not exceed the following:

Maximum Number of Non-Dual Enrollees per Provider by Specialty and Focal Point

Grand Region	Cardiovascular	ENT	Gastroenterology	Neurology	Neurologic Surg	Ophthalmology	Orthopedic Surg	Oncology	Urology
EAST	19,000	45,000	29,500	40,000	53,500	21,500	14,500	75,500	43,500
MIDDLE	22,000	36,000	47,500	35,000	57,500	22,000	17,500	108,500	33,500
WEST	18,800	26,000	29,500	27,000	27,000	15,500	12,000	85,000	23,000

Monitoring

TennCare will monitor MCO compliance with specialist network standards on an on-going basis. Data from the monthly provider file will be used to verify compliance with the specialty network requirements. This file will serve as the source for confirming the MCO has a sufficient number and distribution of specialists and for calculating enrollee to provider ratios. TennCare will also phone providers listed on this file periodically to confirm that the provider is under contract to provide specialty services as reported by the MCO. Appeals data will also be monitored for indications that problems exist with access to specialists, and corrective action plans will be required when appropriate.

**ATTACHMENT V - INSTRUCTIONS FOR COMPLETING THE STERILIZATION CONSENT
FORM**

INSTRUCTIONS FOR COMPLETING THE STERILIZATION CONSENT FORM

1. Enrollee's TennCare Identification Number may be typed, handwritten or left blank.
2. The physician's name, group name or clinic name from whom the enrollee received information about the sterilization procedure. This can be typed or handwritten.
3. Type of sterilization operation to be performed on the enrollee. This can be typed or handwritten.
4. Enrollee's date of birth. The enrollee must be twenty-one (21) years old to sign the sterilization consent form. This can be typed or handwritten.
5. Enrollee's name. This can be typed or handwritten.
6. Physician's name, group name, or clinic if the enrollee is not sure who will be performing the sterilization procedure. This physician does not have to be the same physician who performed the surgery. This can be typed or handwritten.
7. Type of sterilization procedure to be performed. This can be typed or handwritten.
8. Signature of enrollee. The enrollee must simultaneously sign his/her name and date in his/her own handwriting. If the enrollee cannot sign his/her name he/she can make his/her mark "X" in enrollee's signature if there is a witness. The witness must sign down below his/her name and simultaneously date the day they witnessed the enrollee make their mark. This must be in the witness' own handwriting. The witness should write witness beside their name.
9. The enrollee must simultaneously write the date he/she signed the consent form in their own handwriting when signing the consent form.
10. The enrollee should write in the time they signed the consent form. This is only important in cases where the thirty day time period has not lapsed and the 72 hour period between the time the enrollee signed the consent form and the time the sterilization procedure was performed.
11. Race and ethnicity designation is optional.
12. The language used to explain the consent form if an interpreter is used. This can be typed or handwritten.
13. Signature of the interpreter and the date the interpreter signs the consent form. The interpreter must sign his/her name and simultaneously write the date in his/her own handwriting. If an interpreter is not used write NA in the blanks.
14. Name of the individual to be sterilized. This can be typed or handwritten.
15. Type of sterilization operation to be performed. This can be typed or handwritten.
16. Signature of the person obtaining consent and the date he/she signed the consent form. The person who obtained consent must sign and date the consent form simultaneously in his/her own handwriting. The signature of the person obtaining consent and the date must be signed prior to surgery.
17. Name of the facility where the person obtaining consent is located. This can be typed or handwritten.
18. Address of the facility. This can be typed or handwritten.
19. Name of the individual to be sterilized. This can be typed or handwritten.
20. The exact date the sterilization was performed. The date can be typed or handwritten. The date of service on the claim requesting payment must be the same date on the sterilization consent form.

- (A) Thirty calendar days must have lapsed between the date the enrollee signed the consent form and the date the sterilization procedure was performed. Start counting day one (1) the day after the enrollee signs the consent form and then the sterilization can be performed on the 31st day except in the case of premature delivery or emergency abdominal surgery.
- (B) In case of premature delivery, at least 72 hours must have passed between the day and time the enrollee signed the consent form before the sterilization procedure can be performed. At least thirty (30) calendar days would have had to lapse between the date the enrollee signed the consent form and the individual's expected date of delivery.
- (C) In the case of emergency abdominal surgery, at least 72 hours must have passed between the day and time the enrollee signed the consent form before the sterilization procedure can be performed.
- (D) The consent form expires 180 calendar days from the date of the enrollee's signature. Start counting the date the enrollee signed the consent form as day one (1). The procedure must be performed within 180 calendar days.

21. Type of sterilization operation performed. This can be typed or handwritten.

22. Alternative final paragraph instructions:

- (A) Cross out paragraph two (2) if at least thirty (30) calendar days have lapsed between the date of the enrollee's signature on the consent form and the date the sterilization operation was performed.
- (B) Cross out paragraph one (1) if this sterilization was performed less than thirty (30) calendar days but more than 72 hours after the date of the enrollee's signature on the consent form because of premature delivery or emergency abdominal surgery. Check appropriate boxes for premature delivery and individual expected date of delivery and fill in the enrollee's expected date of delivery. Or if emergency abdominal surgery check appropriate box and describe circumstances.

23. Physician's signature. The physician who performed the sterilization procedure must sign his/her name and date he/she signed the consent form simultaneously in his/her own handwriting. The physician must sign the consent form after surgery. The physician's signature, date and time must be in his/her own handwriting. Typed or stamped signatures, initials or dates are not acceptable.

- (A) If the physician signs the consent form the same day as surgery then he/she must specify what time he/she signed the consent form.
- (B) If the physician signs the consent form the same day as surgery and signs the time he/she signed the consent form as 8:00 a.m. or earlier the time surgery ended must be specified below on the consent form.
- (C) If the physician signs the consent form the day after surgery or later then the time the physician signed the consent form may be left blank.

INSTRUCTIONS: COMPLETE AND ATTACH TO CLAIM FORM WHEN SUBMITTING CLAIM FOR PAYMENT.

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS

CONSENT TO STERILIZATION

I was asked for and received information about sterilization from _____

(Doctor or Clinic)

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____

The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not be sterilized will not result in the withholding of any benefits of medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____

(Month, Day, Year)

I, _____ hereby consent of my own free will to be sterilized by _____

(Doctor)

by a method called _____
My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health, Education, and Welfare or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

Signature of Recipient _____ Date _____
Time Signed: _____ AM PM Month Day Year

You are requested to supply the following information, but it is not required:

- Race and ethnicity designation (please check)
- American Indian or Alaska Native Black (not of Hispanic origin)
- Asian or Pacific Islander Hispanic
- White (not of Hispanic Origin)

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized.

I have translated the information and advice presented orally to the individual to be sterilized by a person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

Signature of Interpreter _____ Date _____

STATEMENT OF PERSON OBTAINING CONSENT

Before _____ signed

Name of individual

The consent form, I explained to him/her the nature of the sterilization operation

the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

Signature of person obtaining consent _____ Date _____

Facility _____

Address _____

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon _____ on _____

Name of individual to be sterilized _____ Date of sterilization _____

I explained to him/her the nature of the sterilization operation

Specify type of operation _____
the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

Instructions for use of alternative final paragraphs:

Use the first paragraph below except in case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.

- (1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization operation was performed.
- (2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature in this consent form because of the following circumstances (check applicable box and fill in information request):

- Premature delivery
- Individual's expected date of delivery _____
- Emergency abdominal surgery (describe circumstances)

Physician's Signature _____
Time of Signature _____ AM PM Date of Signature _____

**ATTACHMENT VI - INSTRUCTIONS FOR COMPLETING "CERTIFICATION OF MEDICAL
NECESSITY FOR ABORTION"**

ATTACHMENT VI

Instructions For Completing "Certification Of Medical Necessity For Abortion"

1. **Date of Service:** The date the abortion was performed. This can be typed or handwritten.
2. **Patient's Full Name:** The name of the Mother can be typed or handwritten.
3. **Patient's Social Security Number:** Mother's Social Security Number can be typed or handwritten.
4. **Condition:** Mark the block indicating the applicable reason for the abortion. This can be typed or handwritten.
5. **Supporting Documentation:** Mark the block that applies to the type of supporting documentation. This can be typed or handwritten.
6. **Patient Address:** Patient's complete address. This can be typed or handwritten.
7. **Physician Signature:** The physician must sign his/her name in his/her own handwriting.
8. **Physician Name, Social Security Number and Address:** The physician's name, Social Security Number and complete address. This can be typed or handwritten.

**ATTACHMENT VI
CERTIFICATION OF MEDICAL NECESSITY FOR ABORTION**

DATE OF SERVICE: _____ **1** _____

Based on my professional judgment, I certify that an abortion is medically necessary in the case of:

Patients' Full Name: _____ **2** _____

Patients' Social Security Number: _____ - **3** _____ - _____

for the following reason:

(CHECK ONE) **4**

- There is credible evidence to believe the pregnancy is the result of rape or incest.
- The abortion is medically necessary as the woman suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed.

SUPPORTING DOCUMENTATION: **5**

(PLEASE CHECK THOSE THAT APPLY AND ATTACH DOCUMENTS)

- Documentation from a law enforcement agency indicating the patient has made a credible report as the victim of incest or rape.
- Documentation from a public health agency, Department of Human Services or Counseling agency (such as a Rape Crisis Center) indicating the patient has made a credible report as the victim of incest or rape.
- Medical records documenting the life saving nature of the abortion.
- Other (Please Specify): _____

PATIENT ADDRESS:

_____ **6** _____

PHYSICIAN PERFORMING ABORTION:

SIGNATURE: _____ **7** _____
PHY. NAME: _____ **8** _____
PHY. SS#: _____ - _____ - _____
PHY. ADD.: _____

**ATTACHMENT VI
CERTIFICATION OF MEDICAL NECESSITY FOR ABORTION**

DATE OF SERVICE: _____

Based on my professional judgment, I certify that an abortion is medically necessary in the case of:

Patients' Full Name: _____

Patients' Social Security Number: _____ - _____ - _____

for the following reason:

(CHECK ONE)

- There is credible evidence to believe the pregnancy is the result of rape or incest.
- The abortion is medically necessary as the woman suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed.

SUPPORTING DOCUMENTATION:

(PLEASE CHECK THOSE THAT APPLY AND ATTACH DOCUMENTS)

- Documentation from a law enforcement agency indicating the patient has made a credible report as the victim of incest or rape.
- Documentation from a public health agency, Department of Human Services or Counseling agency (such as a Rape Crisis Center) indicating the patient has made a credible report as the victim of incest or rape.
- Medical records documenting the life saving nature of the abortion.
- Other (Please Specify): _____

PATIENT ADDRESS:

PHYSICIAN PERFORMING ABORTION:

SIGNATURE: _____
PHY. NAME: _____
PHY. SS#: _____
PHY. ADD.: _____

**ATTACHMENT VII - INSTRUCTIONS FOR COMPLETING THE HYSTERECTOMY
ACKNOWLEDGMENT FORM**

INSTRUCTIONS FOR COMPLETING THE HYSTERECTOMY ACKNOWLEDGMENT FORM

Always Complete This Section

1. Enrollee Name: Enrollee's Name can be typed or handwritten. Must be completed.
2. TennCare ID No.: Enrollee's TennCare Number can be typed or handwritten. Must be completed.
3. Physician's Name: Physician's Name can be typed or handwritten. Must be completed.
4. Date of Hysterectomy: Date the hysterectomy was performed. This can be typed or handwritten. Must be completed.

Section A: Complete This Section For Enrollee Who Acknowledges Receipt Prior To Hysterectomy

5. Witness Signature Date: Witness must sign his/her name and date simultaneously in his/her own handwriting prior to surgery.
6. Patient's Signature/Date: Patient must sign her name and date in her own handwriting simultaneously prior to surgery. (If the patient cannot sign her name she can make her mark "X" in patient's signature blank if there is a witness. The witness must sign down below his/her name and simultaneously date the day they witnessed the recipient make their mark. This must be in the witness' own handwriting. The witness should write witness beside their name.

If Section A is completed, STOP HERE.

Section B: Complete This Section When Any Of The Exceptions Listed Below Is Applicable

7. Retroactive Eligible Enrollee Only: This box is checked only if the enrollee was approved retroactively. A copy of the TennCare card, which covers the date of the hysterectomy, or a copy of the retroactive approval notice, must accompany this form before reimbursement can be made.
8. This box is checked if the patient was already sterile prior to surgery. Describe cause of sterility. This can be typed or handwritten.
9. This box is checked if the patient had a hysterectomy performed because of a life-threatening situation and the information concerning sterility could not be given prior to the hysterectomy. Describe the emergency situation. This can be typed or handwritten.
10. Physician's Signature/Date: The physician must sign his/her name and date simultaneously in his/her own handwriting.

Section C: Complete This Section For Mentally – Incompetent Enrollee

11. Witness Signature/Date: Witness must sign his/her name and date simultaneously in his/her own handwriting prior to surgery.
12. Patient Representative Signature/Date: Patient representative must sign his/her name and date simultaneously in his/her own handwriting prior to surgery.
13. Reason For Hysterectomy: Describe the reason for the hysterectomy. This may be typed or handwritten.
14. Physician's Signature/Date: The physician must sign his/her name and date simultaneously in his/her own handwriting after surgery.

**MEDICAID - TITLE XIX
ACKNOWLEDGMENT OF HYSTERECTOMY INFORMATION**

→ALWAYS COMPLETE THIS SECTION←

Recipient Name _____ Medicaid ID No. _____
Physician's Name _____ Date of Hysterectomy _____

→COMPLETE ONLY ONE OF REMAINING SECTIONS: COMPLETE ALL BLANKS IN THAT SECTION←

SECTION A: COMPLETE THIS SECTION FOR RECIPIENT WHO ACKNOWLEDGES RECEIPT PRIOR TO HYSTERECTOMY

I acknowledge receipt of information, both orally and in writing, prior to the hysterectomy's being performed, that if a hysterectomy is performed on me it will render me permanently incapable of reproducing.

WITNESS' SIGNATURE _____ DATE _____ PATIENT'S SIGNATURE _____ DATE _____

SECTION B: COMPLETE THIS SECTION WHEN ANY OF THE EXCEPTIONS LISTED BELOW IS APPLICABLE

I certify that before I performed the hysterectomy procedure on the recipient listed below:

CHECK ONE

- 1 I informed her that this operation would make her permanently incapable of reproducing. (This certification for retroactively eligible recipient only - a copy of the Medicaid card which covers the date of the hysterectomy, or a copy of the retroactive approval notice, must accompany this form before the reimbursement can be made)
- 2 She was already sterile due to _____

CAUSE OF STERILITY

- 3 She had a hysterectomy performed because of a life-threatening situation due to _____

DESCRIBE EMERGENCY SITUATION

and the information concerning sterility could not be given prior to the hysterectomy.

PHYSICIAN'S SIGNATURE _____ DATE _____

SECTION C: COMPLETE THIS SECTION FOR MENTALLY-INCOMPETENT RECIPIENT ONLY

I acknowledge receipt of information, both orally and in writing, prior to the hysterectomy's being performed, that if a hysterectomy is performed on the above recipient, it will render her permanently incapable of reproducing.

WITNESS' SIGNATURE _____ DATE _____ PATIENT REPRESENTATIVE SIGNATURE _____ DATE _____

PHYSICIAN'S STATEMENT

I affirm that the hysterectomy I performed on the above recipient was medically necessary due to _____

REASON FOR HYSTERECTOMY

and was not done for sterilization purposes, and that to the best of my knowledge the individual on whom the hysterectomy was performed is mentally incompetent. Before I performed the hysterectomy on her I counseled her representative, orally and in writing, that the hysterectomy would render that individual permanently incapable of reproducing; and, the individual's representative has signed a written acknowledgment of receipt of the foregoing information.

PHYSICIAN'S SIGNATURE _____ DATE _____

Attach a copy to claim form when submitting for payment. Provide copies for patient and for your files. ADDITIONAL DOCUMENTATION MAY BE REQUESTED BEFORE PAYMENT IS MADE.

THIS FORM MAY BE REPRODUCED LOCALLY

ATTACHMENT VIII - EPSDT SCREENING GUIDELINES

Developmental/Emotional/Behavioral Screening Tools Recommended for Use in EPSDT Screenings

The following chart is a list of measures approved for use in EPSDT screenings. The "Description" column provides information on alternative ways (if available) to administer measures (e.g., waiting rooms). The "Accuracy" column shows the percentage of patients with and without problems identified correctly. The "Time Frame/Costs" column shows the costs of materials per visit along with the costs of professional time needed to administer each measure. For parent report tools, administration time reflects not only scoring of test results, but also the relationship between each test's reading level and the percentage of TennCare patients with less than a high school education (who may or may not be able to complete measures in waiting rooms due to literacy problems and will thus need interview administrations).

Measure	Age range	Description	Scoring	Accuracy	Time Frame/Costs ²
Child Development Inventories (formerly Minnesota Child Development Inventories) (1992) Behavior Science Systems, Box 580274, Minneapolis, MN 55458 (phone: 612-929-6220)	3-72 months	60 yes/no descriptions with separate forms for 0-18 months, 18-36 months, and 3-6 years. Can be mailed to families, completed in waiting rooms, administered by interview or by direct elicitation.	A single cutoff tied to 1.5 standard deviations below the mean	Sensitivity ³ was 75% or greater across studies and specificity ⁴ was 70%.	About 10 minutes (if interview needed) Materials ~\$.40 Admin. ~\$3.40 Total = ~\$3.80
Parents' Evaluations of Developmental Status (PEDS) (1997) Ellsworth & Vandermeer Press, Ltd. P.O. 68164 Nashville, TN 37206 Phone: 615-226-4460; fax: 615-227-0411 http://www.pedtest.com (\$38.99)	Birth to 9 years	10 questions eliciting parents' concerns. Can be administered in waiting rooms or by interview. Also in Spanish. Written at the 5 th grade level. Normed in teaching hospitals and private practice.	Categorizes patients into those needing referrals, screening, counseling, reassurance, extra monitoring	Sensitivity ranged from 74% to 79% and specificity ranged from 70% to 80%.	About 2 minutes (if interview needed) Materials ~\$.31 Admin. ~\$.88 Total = ~\$1.19
Pediatric Symptom Checklist. Jellinek MS, Murphy JM, Robinson J. et al. Pediatric Symptom Checklist: Screening school age children for psychosocial dysfunction. <u>Journal of Pediatrics</u> , 1988; 112:201-209 (the test is included in the article and in the PEDS manual)	6-16 years	35 short statements of problem behaviors to which parents respond with "never," "sometimes," or "often." The PSC screens for academic and emotional/behavioral difficulties.	Single refer/nonrefer score	Sensitivity ranged from 80% to 95%. Specificity in all but one study was 70% to 100%.	About 7 minutes (if interview needed) Materials ~\$.06 Admin. ~\$2.38 Total = ~\$2.44

² Interpretation costs (i.e., the amount of professional time needed to explain results) are not included in the costs total

³ Sensitivity = percentage of children with disabilities identified as probably delayed by a screening test

⁴ Specificity = percentage of children without disabilities identified as probably normal by a screening test

Measure	Age range	Description	Scoring	Accuracy	Time Frame/Costs ²
TOOLS THAT ARE RECOMMENDED FOR SECONDARY SCREENING INVOLVING DIRECT TESTING OF CHILDREN					
Brigance Screens. Billerica, MA: Curriculum Associates, Inc. (1985) 153 Rangeway Road, N. Billerica, MA 01862 (1-800-225-0248)	21-90 months	Seven separate forms, one for each 12 month age range. Taps speech-language, motor, readiness and general knowledge at younger ages and also reading and math at older ages. Uses direct elicitation and observation.	Cutoff and age equivalent scores	Sensitivity and specificity to giftedness and to developmental and academic problems was 70% to 82%.	10 minutes (direct testing only) Materials ~\$.53 Admin. ~\$10.15 Total = ~\$10.68
TOOLS THAT ARE NOT RECOMMENDED BUT ARE ACCEPTABLE FOR AUDIT UNTIL 2003					
Denver-II	0-6	Combination of directly elicited and interview, tapping language, personal-social, gross and fine motor, but not preacademic or academic skills.	Pass/fail/ Questionable/ untestable	Sensitivity 80% and specificity 40% or sensitivity 40% and specificity 80%, depending on how the questionable score is handled.	15 minutes for younger children, 25 minutes for older children (combination of direct and interview items) Materials ~\$.31 Admin. ~\$20.36 Total = ~\$20.67
Informal checklists (such as those imbedded in age-specific encounter forms such as Bright Futures)	0-5	Usually tap different areas but lack scoring criteria, provide no proof that items tap important skills or predict developmental outcome.	None	Unknown, but research shows that informal methods detect fewer than 30% of children with disabilities	Unknown, but most have about 10 items and so may take about 2 minutes Materials ~\$.06 Admin. ~\$2.34 Total: ~\$2.40

Recommendations of the TennCare EPSDT Screening Guidelines Committee
Hearing and Vision Screenings
January 1999

	Recommendations for Hearing Screening		Recommendations for Vision Screening	
	<i>Subjective</i>	<i>Objective</i>	<i>Subjective</i>	<i>Objective</i>
Newborn	<ul style="list-style-type: none"> • Parental perception of hearing • Family history • Wakes to loud noises • Head turning with voice/noise 	<ul style="list-style-type: none"> • ABR or OAE, if performed in hospital • Observational screening with noisemaker (optional) 		<ul style="list-style-type: none"> • Eye exam: red reflex, corneal inspection
2-4 days	<ul style="list-style-type: none"> • Parental perception of hearing • Family history • Responses to voice and noise—parent report 	<ul style="list-style-type: none"> • ABR or OAE, if performed in hospital • Observational screening with noisemaker (optional) 		<ul style="list-style-type: none"> • Eye exam: red reflex, corneal inspection
By 1 month	<ul style="list-style-type: none"> • Parental perception of hearing • Family history (unless previously recorded) • Response to voice and noise—parent report 	<ul style="list-style-type: none"> • Ear exam • Observational screening with noisemaker (optional) 	<ul style="list-style-type: none"> • Parental perception of vision 	<ul style="list-style-type: none"> • Eye exam: red reflex, corneal inspection • Fixes on face, follows with eyes
2 months	<ul style="list-style-type: none"> • Parental perception of hearing • Family history (unless previously recorded) • Response to voice and noise—parent report 	<ul style="list-style-type: none"> • Ear exam • Observational screening with noisemaker (optional) 	<ul style="list-style-type: none"> • Parental perception of vision 	<ul style="list-style-type: none"> • Eye exam: red reflex, corneal inspection • Fixes on face, follows with eyes
3 months	<ul style="list-style-type: none"> • Parental perception of hearing • Family history (unless previously recorded) • Response to voice and noise—parent report 	<ul style="list-style-type: none"> • Ear exam • Observational screening with noisemaker (optional) 	<ul style="list-style-type: none"> • Parental perception of vision 	<ul style="list-style-type: none"> • Eye exam • Fixes and follows each eye

	Recommendations for Hearing Screening		Recommendations for Vision Screening	
	<i>Subjective</i>	<i>Objective</i>	<i>Subjective</i>	<i>Objective</i>
4 months	<ul style="list-style-type: none"> • Parental perception of hearing • Recognizes parent's voice—parent report • Family history (unless previously recorded) 	<ul style="list-style-type: none"> • Ear exam • Observational screening with noisemaker (optional) 	<ul style="list-style-type: none"> • Parental perception of vision 	<ul style="list-style-type: none"> • Eye exam • Fixes and follows each eye
6 months	<ul style="list-style-type: none"> • Parental perception of hearing • Turns to sounds—parental report • Family history (unless previously recorded) 	<ul style="list-style-type: none"> • Ear exam • Observational screening with noisemaker (optional) 	<ul style="list-style-type: none"> • Parental perception of vision 	<ul style="list-style-type: none"> • Eye exam • Fixes and follows each eye
9 months	<ul style="list-style-type: none"> • Parental perception of hearing • Response to voice and noise—parent report • Family history (unless previously recorded) 	<ul style="list-style-type: none"> • Ear exam • Observational screening with noisemaker (optional) 	<ul style="list-style-type: none"> • Parental perception of vision 	<ul style="list-style-type: none"> • Eye exam • Fixes and follows each eye
12 months	<ul style="list-style-type: none"> • Parental perception of hearing • Response to voice and noise—parent report • Family history (unless otherwise recorded) 	<ul style="list-style-type: none"> • Ear exam • Observational screening with noisemaker (optional) 	<ul style="list-style-type: none"> • Parental perception of vision 	<ul style="list-style-type: none"> • Eye exam • Fixes and follows each eye
15 months	<ul style="list-style-type: none"> • Parental perception of hearing • Response to voice and noise—parent report • Family history (unless previously recorded) 	<ul style="list-style-type: none"> • Ear exam • Observational screening with noisemaker (optional) 	<ul style="list-style-type: none"> • Parental perception of vision • Can see small objects 	<ul style="list-style-type: none"> • Eye exam • Can see small objects

	Recommendations for Hearing Screening		Recommendations for Vision Screening	
	<i>Subjective</i>	<i>Objective</i>	<i>Subjective</i>	<i>Objective</i>
18 months	<ul style="list-style-type: none"> • Parental perception of hearing • Response to voice and noise—parent report • Family history (unless previously recorded) 	<ul style="list-style-type: none"> • Ear exam • Observational screening with noisemaker (optional) 	<ul style="list-style-type: none"> • Parental perception of vision • Can see small objects 	<ul style="list-style-type: none"> • Eye exam • Can see small objects
24 months	<ul style="list-style-type: none"> • Parental perception of hearing • Response to voice and noise—parent report • Family history (unless previously recorded) 	<ul style="list-style-type: none"> • Ear exam • Observational screening with noisemaker (optional) 	<ul style="list-style-type: none"> • Parental perception of vision • Can see small objects 	<ul style="list-style-type: none"> • Eye exam • Can see small objects
3 years	<ul style="list-style-type: none"> • Parental perception of hearing 	<ul style="list-style-type: none"> • Ear exam • Hearing screen (optional) • Observational screening with noisemaker (optional) 	<ul style="list-style-type: none"> • Parental perception of vision • Can see small objects 	<ul style="list-style-type: none"> • Eye exam • Ocular alignment, visual acuity (optional) • Can see small objects
4 years	<ul style="list-style-type: none"> • Parental perception of hearing 	<ul style="list-style-type: none"> • Ear exam • Hearing screen (if not done at 3 years) 	<ul style="list-style-type: none"> • Parental perception of vision 	<ul style="list-style-type: none"> • Eye exam • Ocular alignment, visual acuity (if not done at 3 years)
5 years	<ul style="list-style-type: none"> • Parental perception of hearing 	<ul style="list-style-type: none"> • Ear exam • Hearing screen (if not done at 3 or 4 years) 	<ul style="list-style-type: none"> • Parental perception of vision 	<ul style="list-style-type: none"> • Eye exam • Ocular alignment, visual acuity (if not done at 3 or 4 years)
6 years	<ul style="list-style-type: none"> • Parental perception of hearing 	<ul style="list-style-type: none"> • Ear exam • Hearing screen (if not done at 3, 4, or 5 years) 	<ul style="list-style-type: none"> • Parental perception of vision 	<ul style="list-style-type: none"> • Eye exam • Ocular alignment, visual acuity (if not done at 3, 4, or 5 years)

	Recommendations for Hearing Screening		Recommendations for Vision Screening	
	<i>Subjective</i>	<i>Objective</i>	<i>Subjective</i>	<i>Objective</i>
7 years	<ul style="list-style-type: none"> Parental and patient perception of hearing 	<ul style="list-style-type: none"> Ear exam Hearing screen 	<ul style="list-style-type: none"> Parental and patient perception of vision 	<ul style="list-style-type: none"> Eye exam
8 years	<ul style="list-style-type: none"> Parental and patient perception of hearing 	<ul style="list-style-type: none"> Ear exam Hearing screen (if not done at 7 years) 	<ul style="list-style-type: none"> Parental and patient perception of vision 	<ul style="list-style-type: none"> Eye exam
9 years	<ul style="list-style-type: none"> Parental and patient perception of hearing 	<ul style="list-style-type: none"> Ear exam Hearing screen (if not done at 7 or 8 years) 	<ul style="list-style-type: none"> Parental and patient perception of vision 	<ul style="list-style-type: none"> Eye exam
10 years	<ul style="list-style-type: none"> Parental and patient perception of hearing 	<ul style="list-style-type: none"> Ear exam Hearing screen (if not done at 7, 8, or 9 years) 	<ul style="list-style-type: none"> Parental and patient perception of vision 	<ul style="list-style-type: none"> Eye exam Visual acuity
11 years	<ul style="list-style-type: none"> Parental and patient perception of hearing 	<ul style="list-style-type: none"> Ear exam Hearing screen (if not done at 7, 8, 9, or 10 years) 	<ul style="list-style-type: none"> Parental and patient perception of vision 	<ul style="list-style-type: none"> Eye exam Visual acuity (if not done at 10 years)
12 years	<ul style="list-style-type: none"> Parental and patient perception of hearing 	<ul style="list-style-type: none"> Ear exam Hearing screen (if not done at 7, 8, 9, 10, or 11 years) 	<ul style="list-style-type: none"> Parental and patient perception of vision 	<ul style="list-style-type: none"> Eye exam Visual acuity (if not done at 10 or 11 years)
13 years	<ul style="list-style-type: none"> Parental and patient perception of hearing 	<ul style="list-style-type: none"> Ear exam Hearing screen (if not done at 7, 8, 9, 10, 11, or 12 years) 	<ul style="list-style-type: none"> Parental and patient perception of vision 	<ul style="list-style-type: none"> Eye exam Visual acuity (if not done at 10, 11, or 12 years)
14 years	<ul style="list-style-type: none"> Parental and patient perception of hearing 	<ul style="list-style-type: none"> Ear exam Hearing screen 	<ul style="list-style-type: none"> Parental and patient perception of vision 	<ul style="list-style-type: none"> Eye exam Visual acuity
15 years	<ul style="list-style-type: none"> Parental and patient perception of hearing 	<ul style="list-style-type: none"> Ear exam Hearing screen (if not done at 14 years) 	<ul style="list-style-type: none"> Parental and patient perception of vision 	<ul style="list-style-type: none"> Eye exam Visual acuity (if not done at 14 years)

	Recommendations for Hearing Screening		Recommendations for Vision Screening	
	<i>Subjective</i>	<i>Objective</i>	<i>Subjective</i>	<i>Objective</i>
16 years	<ul style="list-style-type: none"> Parental and patient perception of hearing 	<ul style="list-style-type: none"> Ear exam Hearing screen (if not done at 14 or 15 years) 	<ul style="list-style-type: none"> Parental and patient perception of vision 	<ul style="list-style-type: none"> Eye exam Visual acuity (if not done at 14 or 15 years)
17 years	<ul style="list-style-type: none"> Parental and patient perception of hearing 	<ul style="list-style-type: none"> Ear exam Hearing screen (if not done at 14, 15, or 16 years) 	<ul style="list-style-type: none"> Parental and patient perception of vision 	<ul style="list-style-type: none"> Eye exam Visual acuity (if not done at 14, 15, or 16 years)
18 years	<ul style="list-style-type: none"> Parental and patient perception of hearing 	<ul style="list-style-type: none"> Ear exam Hearing screen (if not done at 14, 15, 16, or 17 years) 	<ul style="list-style-type: none"> Parental and patient perception of vision 	<ul style="list-style-type: none"> Eye exam Visual acuity (if not done at 14, 15, 16, or 17 years)
19 years	<ul style="list-style-type: none"> Parental and patient perception of hearing 	<ul style="list-style-type: none"> Ear exam 	<ul style="list-style-type: none"> Parental and patient perception of vision 	<ul style="list-style-type: none"> Eye exam
20 years	<ul style="list-style-type: none"> Parental and patient perception of hearing 	<ul style="list-style-type: none"> Ear exam 	<ul style="list-style-type: none"> Parental and patient perception of vision 	<ul style="list-style-type: none"> Eye exam
21 years	<ul style="list-style-type: none"> Parental and patient perception of hearing 	<ul style="list-style-type: none"> Ear exam 	<ul style="list-style-type: none"> Parental and patient perception of vision 	<ul style="list-style-type: none"> Eye exam

HEARING SCREENING

- Newborn hearing screenings are most likely to occur in hospital with results reported to the primary care provider. Acceptable methods of screening include auditory brainstem response (ABR) and otoacoustic emissions (OAE) with thresholds of 30 dB HL.
- Newborn hearing screening is recommended for all newborn infants. As of January 1999, not all hospitals in the State have the capability of conducting newborn hearing screening. Newborn hearing screenings should be provided for all newborns by the year 2003.
- Recommended testing intervals: The committee recommends an objective hearing screening test once in each of the following age ranges: 3-6, 10-13, 14-18. Screening should be conducted at the first visit during the above listed intervals at which the patient is cooperative.
- Acceptable methods of objective hearing screening include: conventional audiometry, hand-held audiometry, conditioned play audiometry (with a screening level of 20 dB HL at 500, 1000, 2000, and 4000 Hz).
- Positive screening results should lead to referral for diagnostic assessment of hearing. A prompt re-screening may be substituted for immediate referral for diagnostic assessment if the clinician believes the initial screening result is likely to be a false positive. Re-screening should be done within 2-4 weeks rather than waiting until the next scheduled well child visit.

VISION SCREENING

- Recommended testing intervals:
- The committee recommends testing ocular alignment and visual acuity once in the 3-6 year old age range. These procedures should be conducted at the first visit during which the patient is cooperative.
- The committee recommends testing visual acuity once in each of the following age ranges: 10-13, 14-18.
- Acceptable methods for screening ocular alignment include: photoscreening (preferred), unilateral cover test at 10 feet or 3 M, Random Dot E Stereotest at 40 cm (630 secs of arc).

- Acceptable methods for screening visual acuity include: Snellen Letters, Snellen Numbers, Tumbling F, HOTV, Picture Tests, Allen Figures, LH Tests.
- Positive screening results should lead to referral for diagnostic assessment of vision. A prompt re-screening may be substituted for immediate referral for diagnostic assessment if the clinician believes his initial screening result is likely to be a false positive. Re-screening should be done within 2-4 weeks rather than waiting until the next scheduled well child visit.

ATTACHMENT IX - SCOPE OF COVERED BENEFITS UNDER EPSDT

ATTACHMENT IX
Scope Of Covered Benefits Under EPSDT

Note 1: All services other than EPSDT screenings must be medically necessary.

Note 2: DCS "physical custody" means that DCS provides or arranges for the placement of the individual. Some children may be in DCS legal custody, but not physical custody. These are children who have been placed in DCS custody by the court but who live with parents or adoptive parents. TennCare-eligible children in DCS legal but not physical custody receive the same services from the BHOs that children who are not in custody receive.

	Service	MCO Responsibility	BHO Responsibility	DCS Responsibility
1	Acute inpatient hospital services	X		
2	Psychiatric inpatient facility services		X	
3	Outpatient hospital services	X		
4	Outpatient mental health services		X	
5	Physician inpatient services	X		
6	Physician psychiatric inpatient services		X	
7	Physician outpatient services	X (except when diagnosis code 290.xx -319.xx)	X (only when diagnosis code 290.xx - 319.xx)	
8	Inpatient and outpatient substance abuse treatment programs		X <i>(as medically necessary except for enrollees who are children in DCS physical custody; for these children, the BHO is responsible for a maximum of 10 days detox and a maximum lifetime limitation of \$30,000 on inpatient and outpatient substance abuse treatment benefits)</i>	X <i>(for children in DCS physical custody, detox days in excess of 10 and inpatient and outpatient substance abuse treatment benefits in excess of the maximum lifetime limitation of \$30,000)</i>

	Service	MCO Responsibility	BHO Responsibility	DCS Responsibility
9	Lab & x-ray services	X <i>(except for lab services related to psychotropic or substance abuse drugs)</i>	X <i>(lab services related to psychotropic or substance abuse drugs)</i>	
10	Newborn services	X		
11	Hospice care	X		
12	Dental services	X		
13	Vision services	X		
14	Home health care <i>For psychiatric home health care, see categories #4 and #33.</i>	X		
15	Pharmacy	X <i>(except for drugs related to mental health and substance abuse treatment)</i>	X* <i>(for mental health and substance abuse treatment)</i>	
16	Durable medical equipment	X		
17	Medical supplies	X		
18	Emergency ambulance transportation	X <i>(except for transportation related to mental health and substance abuse treatment)</i>	X <i>(for mental health and substance abuse treatment)</i>	
19	Non-emergency ambulance transportation	X <i>(except for transportation related to mental health and substance abuse treatment)</i>	X <i>(for mental health and substance abuse treatment)</i>	
20	Non-emergency transportation to covered services	X <i>(except for transportation related to mental health and substance abuse treatment)</i>	X <i>(for mental health and substance abuse treatment)</i>	

	Service	MCO Responsibility	BHO Responsibility	DCS Responsibility
21	Community health services <i>For Community Mental Health Center services, see categories #4 and #33.</i>	X		
22	Renal dialysis services	X		
23	EPSDT screenings	X		
24	EPSDT diagnostic and treatment services	X <i>(except for mental health and substance abuse problems)</i>	X <i>(for mental health and substance abuse problems)</i>	
25	Developmental assessments	X <i>(unless the child has a previously diagnosed mental illness)</i>	X <i>(if the child has a previously diagnosed mental illness)</i>	
26	Rehabilitation services	X <i>(except for psychiatric rehabilitation services)</i>	X <i>(psychiatric rehabilitation services for children not in DCS physical custody)</i>	X <i>(psychiatric rehabilitation services for children in DCS physical custody)</i>
27	Chiropractic services	X <i>(when determined cost effective by the MCO)</i>		
28	Private duty nursing <i>For psychiatric private duty nursing services, see categories #4 and #33.</i>	X		
29	Speech therapy	X		
30	Sitter Services	X		
31	Convalescent Care Services	X		
32	Organ Transplant and Donor Services	X		
33	Case management	X	X <i>(mental health case management for children not in DCS physical custody)</i>	X <i>(targeted case management for children in State custody or at risk of State custody; mental health case management when</i>

	Service	MCO Responsibility	BHO Responsibility	DCS Responsibility
				<i>medically necessary for children in DCS physical custody)</i>
34	24-hour residential treatment		X <i>(for children not in DCS physical custody)</i>	X <i>(for children in DCS physical custody)</i>
35	Specialized outpatient and symptom management services		X <i>(for children not in DCS physical custody)</i>	X <i>(for children in DCS physical custody)</i>
36	Specialized crisis services		X <i>(for children not in DCS physical custody)</i>	X <i>(for children in DCS physical custody)</i>
37	Children's therapeutic intervention services			X <i>(for children in DCS physical or legal custody)</i>
38	Services in an intermediate care facility for the mentally retarded <i>(covered by TennCare outside the MCOs and BHOs)</i>			
39	Services in a nursing facility <i>(covered by TennCare outside the MCOs and BHOs)</i>			

*Effective July 1, 1998, pharmacy services for mental health and substance abuse drugs are managed and paid for by TennCare outside the BHOs.

The "scope of benefits" provided in the EPSDT Consent Decree (see Section 54) includes the above services. The Consent Decree list is taken from federal statute, which is oriented more toward *types of service providers* than *types of services*. The list from the Consent Decree list is provided below, and services are cross-referenced to the services identified in the above chart.

- (a) Inpatient hospital services (other than services in an institution for mental diseases)—see #1.
- (b) Outpatient hospital services; rural health clinic services; and services offered by a federally qualified health center—see #3, #4, #8, #21.
- (c) Other laboratory and X-ray services—see #9.
- (d) EPSDT services, and family planning services and supplies—for EPSDT services, see all services listed in chart; for family planning services and supplies, see #5, #7, #17, #21.
- (e) Physicians' services; medical and surgical services furnished by a dentist—see #5, #6, #7, and #12.

- (f) Medical care, or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law—see all services listed in chart.
- (g) Home health care services—see #14.
- (h) Private duty nursing services—see #28.
- (i) Clinic services—see #3, #4, #8, #21, #26, and #32.
- (j) Dental services—see #12.
- (k) Physical therapy and related services—see #5, #7, and #21.
- (l) Prescribed drugs, dentures, and prosthetic devices; eyeglasses—see #13, #15, and #17.
- (m) Other diagnostic, screening, preventive, and rehabilitative services—see #23, #24, #25, #26.
- (n) Services in an intermediate care facility for the mentally retarded (other than in an institution for mental diseases)—see #35.
- (o) Inpatient psychiatric services for individuals under 21—see #2.
- (p) Services furnished by a nurse-midwife—see #5, #7, and #21.
- (q) Hospice care—see #11.
- (r) Case management services and TB-related services—for case management services, see #30; for TB-related services, see #1, #3, #5, #7, #9, #15, #17, and #21.
- (s) Respiratory care services—see #14.
- (t) Services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner—see #5, #7, #10.
- (u) Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease—see #24.

Any other medical care, and any type of remedial care recognized under state law, specified by the Secretary of the United States Department of Health and Human Services—see all services on above chart.

ATTACHMENT X - COST-SHARING REQUIREMENTS FOR RETROACTIVE PERIODS

ATTACHMENT X
Retroactive Cost-Sharing Schedules

Enrollee cost-sharing responsibilities for retroactive eligibility periods shall be determined according to the following schedule:

TennCare Deductibles and Out-Of-Pocket Expenditures

Percentage of Poverty	0% - 100%	101% - 199%	200% - Over
Less than 200% of Poverty			
Annual Deductible (Individual)	\$0	\$250	\$250
Annual Deductible (Family)	\$0	\$500	\$500
Annual Deductible (Children)	\$0	\$0	Same as Adults
Out-Of-Pocket Expenses (Individual)	\$0	\$1,000	\$1,000
Out-Of-Pocket Expenses (Family)	\$0	\$2,000	\$2,000
Family Size	Monthly Income	Monthly Income	Monthly Income
1	0 - 650	651 - 1,289	1,290 - Over
2	0 - 871	872 - 1,725	1,726 - Over
3	0 - 1,092	1,093 - 2,163	2,164 - Over
4	0 - 1,312	1,313 - 2,599	2,600 - Over
5	0 - 1,532	1,533 - 3,035	3,036 - Over
6	0 - 1,753	1,754 - 3,473	3,474 - Over
7	0 - 1,974	1,975 - 3,909	3,910 - Over
8	0 - 2,194	2,195 - 4,345	4,346 - Over
9	0 - 2,415	2,416 - 4,783	4,784 - Over
10*	0 - 2,635	2,636 - 5,219	5,220 - Over
*For each family member over 10, add per month	0 - 219	220 - 435	436 - Over

ATTACHMENT X
Retroactive Cost-Sharing Schedules

TennCare Co-Pay Sliding Scale

Percentage of Poverty	0% - 100%	101% - 119%	120% - 139%	140% - 169%	170% - 199%	200% - Over
Family Size	Monthly Income					
1	0 - 650	651 - 773	774 - 902	903 - 1,096	1,097 - 1,289	1,290 - Over
2	0 - 871	872 - 1,035	1,036 - 1,207	1,208 - 1,466	1,467 - 1,725	1,726 - Over
3	0 - 1,092	1,093 - 1,297	1,298 - 1,514	1,515 - 1,838	1,839 - 2,163	2,164 - Over
4	0 - 1,312	1,313 - 1,559	1,560 - 1,819	1,820 - 2,209	2,210 - 2,599	2,600 - Over
5	0 - 1,532	1,533 - 1,821	1,822 - 2,124	2,125 - 2,580	2,581 - 3,035	3,036 - Over
6	0 - 1,753	1,754 - 2,083	2,084 - 2,431	2,432 - 2,952	2,953 - 3,473	3,474 - Over
7	0 - 1,974	1,975 - 2,345	2,346 - 2,736	2,737 - 3,323	3,324 - 3,909	3,910 - Over
8	0 - 2,194	2,195 - 2,607	2,608 - 3,041	3,042 - 3,693	3,694 - 4,345	4,346 - Over
9	0 - 2,415	2,416 - 2,869	2,870 - 3,348	3,349 - 4,065	4,066 - 4,783	4,784 - Over
10*	0 - 2,635	2,636 - 3,131	3,132 - 3,653	3,654 - 4,436	4,437 - 5,219	5,220 - Over
*For each family member over 10 add per month	0 - 219	220 - 261	262 - 304	305 - 370	371 - 435	436 - Over
Percentage of Payments for Adults	0%	2%	4%	6%	8%	10%
Percentage of Payments for Children	0%	2%	2%	2%	2%	10%

Special Fees

Service	Fee
Emergency Room Services (non-emergency room situations)	\$25 Per Visit For Non-Medicaid Eligible Enrollees

ATTACHMENT XI - COST SHARING SCHEDULES

**ATTACHMENT XI
Cost-Sharing Schedules**

1. Out-of-Pocket Expenditures

The TENNCARE deductible for children, individuals and families shall be \$0.00. The annual TENNCARE maximum out-of-pocket expenditures described below shall apply for both uninsured and uninsurable designations.

Poverty Level	Individual Maximum Annual Out-of-Pocket	Family Maximum Annual Out-of-Pocket
0%-100%	\$0.00	\$0.00
101% - 199%	\$1,000.00	\$2,000.00
200% and above	\$2,000.00	\$4,000.00

2. Copayments

The following TENNCARE copayment schedule shall apply for both Uninsured and Uninsurable designations, based on the poverty level specified in TENNCARE rule 1200-13-12-.05(1)(c):

Poverty Level	Copayment Amounts
0%-100%	\$0.00
101% - 199%	\$25.00, Hospital Emergency Room (waived if admitted) \$5.00, Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care \$15.00, Physician Specialists \$5.00, Prescription or Refill \$100.00, Inpatient Hospital Admission
200% and above	\$50.00, Hospital Emergency Room (waived if admitted) \$10.00, Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care \$25.00, Physician Specialists \$10.00, Prescription or Refill \$200.00, Inpatient Hospital Admission

The CONTRACTOR is specifically prohibited from waiving or discouraging TENNCARE enrollees from paying the amounts described in this provision.

ATTACHMENT XII - REPORTING REQUIREMENTS

The CONTRACTOR and TENNCARE are responsible for complying with all the reporting requirements established by the parties. Both parties are responsible for assuring the accuracy and completeness of all reports as well as the timely submission of each report. Both parties will agree to the appropriate reporting formats, instructions, submission timetables, and technical assistance as required.

**ATTACHMENT XII, EXHIBIT A - REPORTING ENROLLEE INFORMATION/
REQUIRED DATA ELEMENTS**

ATTACHMENT XII, EXHIBIT A
Required Data Elements For Reporting Enrollee Information

This report shall include, at a minimum, the following data elements:

1. Enrollee's name;
2. Enrollee's social security number;
3. Enrollee's date of birth;
4. Enrollee's sex;
5. Enrollee's previous address;
6. Enrollee's new address; or

To the extent possible, a statement or indicator that the enrollee's new address is unknown due to mail being returned for insufficient address (e.g., undeliverable, no forwarding address, etc.) if the enrollee's new address is unknown;

7. Date enrollee moved;
8. A statement or indicator whether the enrollee's new address is within the same community service area as the former address or is in a different community service area;
9. Identity of the new MCO plan, if known, if the enrollee has moved outside the former community service area and desires to change MCO plans;
10. The identity of the MCO providing notice; and
11. Other pertinent information which is known by the CONTRACTOR which may have an affect on an enrollee's eligibility or cost sharing status.

**ATTACHMENT XII, EXHIBIT B – ENROLLEE VERIFICATION
REPORTING/REQUIRED DATA ELEMENTS**

ATTACHMENT XII, EXHIBIT B
Required Data Elements For Enrollee Verification Reporting

In response to receipt of a file from TENNCARE that identifies individuals whom TENNCARE has not been successful at contacting to verify eligibility, the CONTRACTOR will provide a response file that will include, at a minimum, the following data elements:

1. Enrollee's social security number;
2. Enrollee's date of birth;
3. Enrollee's sex;
4. Enrollee's name; and
5. Enrollee's address.

**ATTACHMENT XII, EXHIBIT C - PROVIDER ENROLLMENT
REPORTING/REQUIRED DATA ELEMENTS**

ATTACHMENT XII, EXHIBIT C
Required Data Elements For Provider Enrollment Reporting

This provider listing shall include, at a minimum, the following data elements:

1. Provider name;
2. Provider address, including the address of all service sites operated by the provider;
3. Provider social security or employer I.D. number;
4. Provider's race and/or national origin;
5. Provider Specialty and subspecialty;
6. Provider license number and type of license (if applicable);
7. Provider numbers used in the plan of other payers, including but not limited to, Medicare, Medicaid, other private health plans, etc.;
8. The identification number that will be used by the CONTRACTOR when payment is made to the provider (if multiple numbers are used for payments, then item seven must carry the old Medicaid or Medicare I.D. number to the extent Medicaid or Medicare assigned I.D. numbers for this type provider);
9. Unique Physician Identifier Number - UPIN (if applicable);
10. Provider telephone number;
11. Provider's Drug Enforcement Agency (DEA) number (if applicable);
12. Effective date of participation and closure date of participation (if applicable);
13. In plan/Out-of-plan Indicator;
14. Indicate whether or not the following services are provided by the provider: Obstetrics, General Surgery, Pediatrics, or EPSDT;
15. Is the provider board certified or board eligible;
16. The provider's service delivery county of practice; and
17. Indicate whether or not the provider's practice is limited to male or female patients;

For Dentists and Primary Care Providers (PCP) the following additional data elements are required:

18. Is the Dental / PCP's practice closed to new TennCare members as primary care patients;

For Primary Care Providers (PCPs only) the following additional data elements are required:

19. Does the PCP deliver babies;
17. Does the PCP provide prenatal care;
20. What is the youngest age each individual PCP will accept as a patient into the PCP's practice? (Age zero (00) equates to providing services to newborns);

21. What is the oldest age each individual PCP will accept as a patient into the PCP's practice? (Age 99 equates to Age 99 and older); and
22. How many members has the MCO assigned to each individual PCP for primary care service delivery?

ATTACHMENT XII, EXHIBIT D -- ESSENTIAL HOSPITAL SERVICES CHART

ATTACHMENT XII, EXHIBIT D

Instructions for Completing the Essential Hospital Services Chart

This report is to be prepared based on the MCO's provider network for essential hospital services in each Grand Region in which the MCO has (or expects to have) TennCare enrollees.

- Fill out one report for each Grand Region. In the top portion of the grid, indicate the MCO name, the Grand Region, the total number of MCO enrollees in the Grand Region and the date that such total enrollment was established.
- The MCO should provide information on each Tertiary Care Facility with which that MCO has a contractual or out-of-network relationship for serving enrollees in the identified Grand Region. The MCO should use a separate row to report information on each such Tertiary Care Facility.
 1. In the first column, "Tertiary Care Facility" indicate the complete name of the Tertiary Care Facility.
 2. In the second column: "City/Town" indicate the City or Town in which the designated facility is located.
 3. In the third column: "CSA", indicate the name of the TennCare Community Service Area (CSA) in which this facility is located.
 4. In the fourth through the tenth columns indicate the status of the MCO's relationship with the specific Tertiary Care Facility for each of these covered hospital services, e.g. Neonatal, Perinatal, Pediatric, Trauma, Burn, Center of Excellence for AIDS and Center of Excellence for Children at Risk or in State Custody.
 - For example, if the MCO has an executed contract with the Tertiary Care Facility for Neonatal services, insert an "E" in the column labeled "Neonatal".
 - If an MCO does not have an executed contract with this Tertiary Care Facility for "Neonatal", but has another type of arrangement with this facility, the MCO should indicate the code that best describes its relationship with the facility (e.g. L=letter of intent; R=on referral basis; N=in contract negotiations; O=other arrangement). For any facility in which the MCO does not have an executed contract but is using as an out of network provider, the MCO should submit a brief description (one paragraph) of its relationship with the Tertiary Care Facility including a estimated timeline for executing a contract, if any.
 - If an MCO does not have any relationship for Neonatal services with the Tertiary Care Facility on this row, the MCO should leave the column labeled "Neonatal" blank.

ATTACHMENT XII, EXHIBIT D
Essential Hospital Services

MCO Name: _____

Grand Region: _____

Number of MCO Enrollees: _____

As of (date): _____

Name of Tertiary Care Facility	City/Town	CSA	Neonatal	Perinatal	Pediatric	Trauma	Burn	AIDS Center of Excellence	Children at risk or in Custody COE	Comments

- E = Executed Contract
- L = Letter of Intent
- R = On Referral Basis
- N = In Contract Negotiations
- O = Other Arrangement

**ATTACHMENT XII, EXHIBIT E – SPECIALTY PHYSICIAN SERVICES
REPORTING**

ATTACHMENT XII, EXHIBIT E

Instructions for Completing the Specialty Physician Services Chart

This report is to be prepared based on the MCO's provider network for specialty services in each Grand Region in which the MCO has (or expects to have) TennCare enrollees.

- Fill out one report for each Grand Region. In the top portion of the grid, indicate the MCO name, the Grand Region, the total number of MCO enrollees in the Grand Region and the date that such total enrollment was established.
 - The MCO should provide information on each Specialty Provider with which that MCO has an out-of-network relationship for serving enrollees in the identified Grand Region. The MCO should use a separate row to report information on each such specialty. This chart should NOT include contracted physician specialty providers that are included in the monthly provider files submitted to TENNCARE by the CONTRACTOR.
1. In the first column, "Provider" indicate the complete name of the Specialty Provider.
 2. In the second column: "City/Town" indicate the City or Town in which the designated physician office is located.
 3. In the third column: "CSA", indicate the name of the TennCare Community Service Area (CSA) in which this physician office is located.
 4. In the fourth column: "STATUS", indicate the status of the MCO's relationship with the specific provider. For example, if the MCO has a letter of agreement with the provider, insert an "L" in this column. If an MCO has another type of arrangement with this provider, the MCO should indicate the code that best describes its relationship with the provider (e.g. R=on referral basis; N=in contract negotiations; O=other arrangement).
 5. In the Comments column, the MCO should add relevant comments regarding its relationship with the specialist, including a estimated timeline for executing a contract.

ATTACHMENT XII, EXHIBIT E
Specialty Physician Services

MCO Name: _____

Grand Region: _____

Number of MCO Enrollees: _____

As of (date): _____

Provider Name	City/Town	CSA	STATUS	Specialty	Comments

E = Executed Contract
 L = Letter of Intent
 R = On Referral Basis
 N = In Contract Negotiations
 O = Other Arrangement

**ATTACHMENT XII, EXHIBIT F - REPORTING OTHER INSURANCE/REQUIRED DATA
ELEMENTS**

ATTACHMENT XII, EXHIBIT F
Required Data Elements For Reporting Other Insurance

This report shall include, at a minimum, the following data elements:

1. Enrollee's name;
2. Enrollee's social security number;
3. Enrollee's date of birth;
4. Enrollee's group insurance number;
5. Enrollee's individual insurance number;
5. Policy limitations;
6. Policy benefits;
8. Beginning effective date of enrollee coverage;
9. Ending effective date of enrollee coverage (if applicable); 10 Name of insured policyholder;
10. Social security number of insured policyholder; and
11. Type of insurance coverage (employer, individual, etc.).

**ATTACHMENT XII, EXHIBIT G - INDIVIDUAL ENCOUNTER REPORTING/REQUIRED
DATA ELEMENTS**

ATTACHMENT XII, EXHIBIT G
Required Data Elements For Reporting Individual Encounters

This report shall include, at a minimum, the following data elements:

Common Data Elements

Type of Claim
 Provider Number Servicing
 Provider Number
 Primary Care Provider Number (Effective July 1, 1997)
 Enrollee Number
 Procedure Code
 (CPTs and NDCs)
 Procedure Modifier
 Type of Service
 Units
 From Date
 Through Date
 Payment Date
 Billed Charges
 Allowed Amount
 Amount Paid
 Primary Diagnosis
 Secondary Diagnosis
 Diagnosis 3
 Diagnosis 4
 Diagnosis 5
 Provider Type
 Provider Specialty
 Claim Type Modifier
 Third Party Liability Amount

Hospital Specific

Attending Physician
 Admitting Physician
 Discharge Date
 Admit Date
 Covered Days
 Non-Covered Days
 UB-82 revenue Codes
 (UB-92 When Implemented)
 Revenue Charges
 Surgical Procedures (ICD-9)
 Per Diem
 Bill Type
 DRG Data
 Admitting Diagnosis
 Discharge Diagnosis

Home Health Specific

Attending Physician

Professional Specific

Referring Provider Number
 Treatment Place
 Anesthesia Units

Community Health Clinic Specific

Drug Codes
 Drug Quantity
 Drug Day Supply
 Drug Charges
 Treatment Place
 Referring Provider Number

Ambulance Specific

Emergency Date
 Referring Provider Number
 Destination

Dental Specific

Tooth Number
 Tooth Surface
 Emergency Indicator

Pharmacy Specific

Prescribing Provider Number
 Prescription Number
 Refill Number
 Days Supply
 Nursing Home Indicator
 Unit Dose Indicator

Hospice Specific

Certification Date
 Attending Physician
 Admitting Physician
 Date Care Begins
 Treatment Place
 Covered Days

ATTACHMENT XII, EXHIBIT H – WEEKLY CLAIMS ACTIVITY REPORT

ATTACHMENT XII, EXHIBIT H

Instructions for Completing the Weekly Claims Activity Report

This report is to be prepared based on the type of claim form received (i.e., HCFA 1500, UB 92, dental) rather than the type of service billed on the claim (i.e., physician services, inpatient, durable medical equipment). Claims processed by a subcontractor should be reported separately from those claims received and processed by the MCO. Each subcontractor should be identified and the claims information relating to that subcontractor's weekly claims should be reported.

Instructions for completing the report:

- Report the number of claims received for the week but not yet entered into the electronic claims processing system in the column labeled **"Number of Claims Awaiting Input"**.
- Report the number of claims, by age, input into the electronic claims processing system but not yet processed to final adjudication in the appropriate columns labeled **"Aging of Claims Input But Not Adjudicated to Final Disposition (i.e., pending or in process)"**. The age of the claims reported in this field shall begin on the date of receipt of the claim and include any amounts of time the claim was awaiting input into the electronic claims processing system.
- Report the billed amount and expected reimbursement amount for the claims identified in the aging component of the report in the appropriate columns under the heading labeled **"Value of Claims Pending or In Process"**.
- Report the average turn-around time for claims processed to final adjudication for the week in the appropriate column labeled **"Average Turnaround Time for Adjudicated Claims"**.

ATTACHMENT XII, EXHIBIT H
Weekly Claims Activity Report

MCO Name: _____

For the Week Ending: _____

Claim Type	Number of Claims Awaiting Input	Aging of Claims Input But Not Adjudicated to Final Disposition (i.e., pending or in process)				Value of Claims Pending or In Process		Average Turnaround Time for Adjudicated Claims For Claims Paid The Current Week
		1 - 30 Days	31 - 60 Days	> 60 Days	Total	Billed Amount	Expected Reimbursement	
HCFA 1500								
UB 92								
Dental								
Claims Processed by Subcontractors: (List Individual Subcontractors)								
Totals								

ATTACHMENT XII, EXHIBIT I – WEEKLY ACTIVITY REPORT

ATTACHMENT XII, EXHIBIT I

Instructions for Completing the Weekly Activity Report

The following definitions should be used for the purpose of completing the Weekly Activity Report.

- Definitions for reporting Member statistics:

Abandoned Call: A call in the Member Services telephone line queue that is terminated by the caller before reaching a Member Services Representative after waiting at least 20 seconds.

Abandonment Rate: Number of abandoned calls divided by call volume.

Average Time to Answer: The average time that callers waited in the Member Services telephone queue that were during normal business hours before speaking to a Member Services Representative, report in minutes: seconds (e.g. one minute and twenty-five seconds should be reported as 1:25).

- Definitions for reporting Provider statistics:

Abandoned Call: A call in the Provider Services Prior Authorization line queue that is terminated by the caller before reaching a Provider Services Representative after waiting at least 20 seconds.

Abandonment Rate: Number of abandoned calls divided by call volume.

Average Time to Answer: The average time that callers waited in the Provider Services Prior Authorization telephone queue, that were during normal business hours, before speaking to a Provider Services Representative. Report in minutes: seconds (e.g. one minute and twenty-five seconds should be reported as 1:25).

NOTE: When calculating the Abandonment Rate and the Average Call Response time exclude all calls from both the numerator and denominator that were terminated by the caller while in the queue for less than 20 seconds.

ATTACHMENT XII, EXHIBIT I
Weekly Activity Report

MCO Name: _____

For the Week Ending: _____

MEMBER PHONE CALLS

A. Number of Member Phone Calls Received _____

B. Abandonment rate for Member Calls _____

(% of total calls
received)

C. Approximate Phone Queue Waiting Time for Member Response _____

Report in
minutes: seconds

PROVIDER PHONE CALLS

A. Number of Provider Phone Calls for Prior Authorizations _____

B. Approximate Phone Queue Waiting Time for Prior
Authorization Response _____

Report in
minutes: seconds

PROVIDER COMPLAINTS

A. Number of Provider Complaints, received in Writing or by Phone _____

ATTACHMENT XII, EXHIBIT J – CLAIMS LAG TABLES

ATTACHMENT XII, EXHIBIT J.1
UB92 Payments by the Claims Processing System

		Incurred Month of Service																			
		Total	Jul-01	Aug-01	Sep-01	Oct-01	Nov-01	Dec-01	Jan-02	Feb-02	Mar-02	Apr-01	May-02	Jun-02	Jul-02	Jul-02	Aug-02	Sep-02	Oct-02	Nov-02	Dec-02
Month	Jul-01	0																			
Paid	Aug-01	0																			
by the	Sep-01	0																			
Claims	Oct-01	0																			
System	Nov-01	0																			
	Dec-01	0																			
	Jan-02	0																			
	Feb-02	0																			
	Mar-02	0																			
	Apr-02	0																			
	May-02	0																			
	Jun-02	0																			
	Jul-02	0																			
	Aug-02	0																			
	Sep-02	0																			
	Oct-02	0																			
	Nov-02	0																			
	Dec-02	0																			
	Jan-03	0																			
	Feb-03	0																			
	Mar-03	0																			
	Apr-03	0																			
	May-03	0																			
	Jun-03	0																			
Total Paid		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
IBNR Estimate*		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
GRAND TOTAL		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

*IBNR estimate for budgeting purposes. Actuarial certification not required.

ATTACHMENT XII, EXHIBIT J.2
HCFA 1500 Payments by the Claims Processing System

		Incurred Month of Service																			
		Total	Jul-01	Aug-01	Sep-01	Oct-01	Nov-01	Dec-01	Jan-02	Feb-02	Mar-02	Apr-01	May-02	Jun-02	Jul-02	Jul-02	Aug-02	Sep-02	Oct-02	Nov-02	De
Month	Jul-01	0																			
Paid	Aug-01	0																			
by the	Sep-01	0																			
Claims	Oct-01	0																			
System	Nov-01	0																			
	Dec-01	0																			
	Jan-02	0																			
	Feb-02	0																			
	Mar-02	0																			
	Apr-02	0																			
	May-02	0																			
	Jun-02	0																			
	Jul-02	0																			
	Aug-02	0																			
	Sep-02	0																			
	Oct-02	0																			
	Nov-02	0																			
	Dec-02	0																			
	Jan-03	0																			
	Feb-03	0																			
	Mar-03	0																			
	Apr-03	0																			
	May-03	0																			
	Jun-03	0																			
	Total Paid	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	IBNR Estimate*	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	GRAND TOTAL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

*IBNR estimate for budgeting purposes. Actuarial certification not required.

ATTACHMENT XII, EXHIBIT J.4
Dental Payments by the Claims Processing System

		Incurred Month of Service																			
		Total	Jul-01	Aug-01	Sep-01	Oct-01	Nov-01	Dec-01	Jan-02	Feb-02	Mar-02	Apr-01	May-02	Jun-02	Jul-02	Jul-02	Aug-02	Sep-02	Oct-02	Nov-02	Dec-02
Month	Jul-01	0																			
Paid	Aug-01	0																			
by the	Sep-01	0																			
Claims	Oct-01	0																			
System	Nov-01	0																			
	Dec-01	0																			
	Jan-02	0																			
	Feb-02	0																			
	Mar-02	0																			
	Apr-02	0																			
	May-02	0																			
	Jun-02	0																			
	Jul-02	0																			
	Aug-02	0																			
	Sep-02	0																			
	Oct-02	0																			
	Nov-02	0																			
	Dec-02	0																			
	Jan-03	0																			
	Feb-03	0																			
	Mar-03	0																			
	Apr-03	0																			
	May-03	0																			
	Jun-03	0																			
Total Paid		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
IBNR Estimate*		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
GRAND TOTAL		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

*IBNR estimate for budgeting purposes. Actuarial certification not required.

**ATTACHMENT XII, EXHIBIT K
FQHC Reporting**

MCO Name: _____

As of January 1, _____

Please provide the information identified below for each FQHC in the provider network..

1. FQHC Name: _____
2. FQHC Address: _____

3. Please describe the reimbursement arrangement (check one):

- Fee-for-service, cost-related basis
- Capitated basis, considering adverse selection factors

4. If capitated, please explain what adjustments are made for adverse selection and attach a copy of the rates:

5. Covered Services (describe the types of services the FQHC is contracted to provide)

6. Total Amount Paid for the previous twelve (12) month period from July 1 through June 30:

**ATTACHMENT XII, EXHIBIT L – QUARTERLY REPORT OF APPEALS AND
RESOLUTION**

ATTACHMENT XII, EXHIBIT L

Instructions For Completing Quarterly Report Of Appeals And Resolution

Section 2-8.a.8 requires MCOs to provide reports of appeals to TENNCARE including recommendations to, and actions taken by the QI Committee. This report, entitled The Quarterly Report of Appeals and Resolution, should be submitted on a quarterly basis, within 30 days of the end of the quarter, to the Director of TennCare Solutions.

MCO Name: Enter the name of the MCO for which the report is being completed

Report Period: Check the appropriate quarter and indicate the year for which results are reported.

Average Number of Enrollees: Report the average number of TennCare enrollees enrolled in the plan during the report period.

Number of Mute Appeals: Report the number of appeals sent to the MCO for reconsideration that did not result in a decision by the MCO because it was already resolved (e.g., at the place of service) or redirected for resolution (e.g., to the BHO).

Number of Appeal Issues Resolved by Type: Report the number of each type of issue resolved during the report period. If an appeal has multiple issues, each issue should be counted separately.

Number of Appeals decided fully in favor of enrollee: Report the number of appeals that were overturned upon reconsideration in favor of the enrollee during the report period. If the appeal involves multiple components and only a portion of the appeal was decided in favor of the enrollee, count the appeal under "number of appeals not decided fully in favor of enrollee".

Number of Appeals not decided fully in favor of enrollee: Report the number of appeals that were not decided upon reconsideration fully in favor of the enrollee. Include appeals that were decided only partially in favor of the enrollee.

Average Number of Days to Process Regular Appeals: Report the average number of days to process non-expedited appeals from receipt of the appeal to notification of decision.

Average Number of Days to Process Expedited Appeals: Report the average number of days to process expedited appeals from receipt of the appeal to notification of decision.

Summary of recommendations to QI Committee: Summarize any recommendations made to the QI Committee during the quarter based on an analysis of appeals reviewed by the MCO.

Summary of actions taken by QI Committee: Summarize any actions taken by the QI Committee during the quarter based on recommendations that came from an analysis of appeals reviewed by the MCO.

**ATTACHMENT XII, EXHIBIT L
Quarterly Report Of Appeals And Resolution**

MCO Name:

- Report Period:**
- January 1 – March 31, 200X
 - April 1 – June 30, 200X
 - July 1 – September 30, 200X
 - October 1 – December 31, 200X

Average Number of Enrollees:

- Number of Appeal Issues Resolved by Type:**
- _____ Difficulty Scheduling PCP appt.
 - _____ No Specialist Available
 - _____ Difficulty Scheduling Specialist appt.
 - _____ Dental Services
 - _____ EPSDT Services
 - _____ Home Health
 - _____ Inpatient Care
 - _____ Prescription Drugs (excluding Reimbursement)
 - _____ Billing/Reimbursement Dispute
 - _____ Quality of Medical Care
 - _____ Quality of Service
 - _____ PCP Change Request
 - _____ Transportation
 - _____ Other
 - _____ TOTAL

Number Appeals	of	Mute	Number XXX		Percent of Total X.XX%
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**ATTACHMENT XII, EXHIBIT L
Quarterly Report Of Appeals And Resolution**

Number of Appeals XXX X.XX%
decided fully in favor of
enrollee

Number of Appeals not XXX X.XX%
decided fully in favor of
enrollee

Number of Appeals XXX X.XX%
decided on an expedited
basis

Average Number of XXX NA
Days to Process Regular
Appeals

Average Number of XXX NA
Days to Process
Expedited Appeals

Summary of recommendations made to QI Committee based on appeals:

Summary of actions taken by QI Committee:
